WSR 20-15-024
PERMANENT RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Dockets UE-170002 and UG-170003, General Order R-599—Filed July 7, 2020, 1:12 p.m., effective August 7, 2020]

In the matter of amending WAC 480-07-510 and adopting chapter 480-85 WAC, relating to cost of service studies for electric and natural gas investor-owned utilities.

1 **STATUTORY OR OTHER AUTHORITY:** The Washington utilities and transportation commission (commission) takes this action under Notice No. WSR 20-05-033, filed with the code reviser on February 11, 2020. The commission has authority to take this action pursuant to RCW 80.01.040, 80.04.160; and chapter 80.28 RCW.

2 **STATEMENT OF COMPLIANCE:** This proceeding complies with the Administrative Procedure Act (chapter 34.05 RCW), the State Register Act (chapter 34.08 RCW), the State Environmental Policy Act of 1971 (chapter 43.21C RCW), and the Regulatory Fairness Act (chapter 19.85 RCW).

3 **DATE OF ADOPTION:** The commission adopts this rule on the date this order is entered.

4 **CONCISE STATEMENT OF PURPOSE AND EFFECT OF THE RULE:** RCW 34.05.325(6) requires the commission to prepare and publish a concise explanatory statement about an adopted rule. The statement must identify the commission's reasons for adopting the rule, describe the differences between the version of the proposed rules published in the register and the rules adopted (other than editing changes), summarize the comments received regarding the proposed rule changes, and state the commission's responses to the comments reflecting the commission's consideration of them.

5 To avoid unnecessary duplication in the record of this docket, the commission designates the discussion in this order, including appendices, as its concise explanatory statement. This order provides a complete but concise explanation of the agency's actions and its reasons for taking those actions.

6 **REFERENCE TO AFFECTED RULES:** This order amends and adopts the following sections of the Washington Administrative Code: Amending WAC 480-07-510 General rate proceeding filings—Electric, natural gas, pipeline, and Class A telecommunications companies; and adopting WAC 480-85-010 Purpose, 480-85-020 Applicability, 480-85-030 Definitions, 480-85-040 Minimum filing requirements, 480-85-050 Cost of service study inputs.

Adopt WAC 480-85-060 Cost of service methodology, 480-85-070 Exemptions from rules in chapter 480-85 WAC.

7 **ACTIONS PRIOR TO PREPROPOSAL STATEMENT OF INQUIRY:** In Final Order 06 of *Wash. Utils. & Transp. Comm'n v. Avista Corp., d/b/a Avista Utils.*, Dockets UE-160228 and UG-160229, the commission ordered: A collaborative effort with interested stakeholders, preferably including representatives of all investor-owned utilities in Washington, to more clearly define the scope and expected outcomes of, as well as a reasonable procedural schedule for, generic cost of service proceedings that will provide an opportunity to establish greater clarity and some degree of uniformity in cost of service studies going forward.[1]

1 *Wash. Utils. & Transp. Comm'n v. Avista Corp. d/b/a Avista Utils.*, Dockets UE-160228 and UG-160229 (consolidated), Final Order 06, Rejecting Tariff Filing, 57-58, ¶ 116 (Dec. 15, 2016); *see also id.* at 55, ¶ 100.

8 Prior to initiating the proceeding, the commission engaged with stakeholders to clearly define the scope, expected outcomes, and appropriate procedure for undertaking its effort to establish greater clarity and uniformity in cost of service studies.[2] On February 8, 2017, the commission held a cost of service collaborative meeting with both investor-owned electric and natural gas utilities and interested stakeholders to solicit ideas and input from all attendees on the goals and most appropriate procedure for conducting a generic proceeding to establish clarity and uniformity in cost of service studies.

2 *See id.* at 55, ¶ 100.

9 On February 16, 2018, the commission convened various stakeholders, including the investor-owned electric utilities in Washington, to compare cost of service methodologies used by each electric utility, discuss the history of cost of service in Washington, and consider the appropriate procedure going forward. On March 6, 2018, the commission solicited comments regarding which topics should be included in a rule-making proposal for cost of services studies. From March 23 to April 24, 2018, the commission received written comments from The Energy Project, the public counsel unit of the Washington Attorney General's Office (public counsel), PacifiCorp, d/b/a Pacific Power & Light Company (PacifiCorp), Avista Corporation, d/b/a Avista Utilities (Avista), Puget Sound Energy (PSE), and The Kroger Company (Kroger).

10 On April 20, 2018, the commission held a natural gas cost of service meeting with various stakeholders, including the investor-owned natural gas utilities in Washington, to compare the similarities and differences of natural gas utilities, identify the scope of the generic proceeding, and further discuss the appropriate procedure going forward. On April 24, 2018, the commission solicited comments from natural gas investor-owned utilities and stakeholders regarding what topics should be included in a rule-making proposal for cost of services studies. From May 25 to May 31, 2018, the commission received written comments from Public Counsel, Avista, PSE, Cascade Natural Gas Corporation (Cascade), and the Alliance of Western Energy Consumers (AWEC).

11 Based on the discussions at the electric and natural gas collaborative meetings and the written comments received, the commission determined that it should initiate a rule making regarding cost of service studies.

12 **PREPROPOSAL STATEMENT OF INQUIRY AND ACTIONS THEREUNDER:** The commission filed with the code reviser a Preproposal statement of inquiry (CR-101) on July 19, 2018, at WSR 18-16-005, and filed the CR-101 in Dockets UE-170002 and UG-170003. The statement advised interested persons that the commission was initiating a rule making to streamline the submission and evaluation of cost of service studies by developing an accurate, transparent, and effective method and process for parties to present cost of service studies in general rate proceedings; standardizing presentations of cost of service studies and supporting informa-

tion; and reducing the administrative burden on companies, intervenors, and the commission during general rate cases while preserving individual stakeholder ability to present alternative opinions.

13 On July 23, 2018, the commission issued a notice of opportunity to file written comments, informing persons of this inquiry by providing notice of the subject and the CR-101 to everyone on the commission's list of persons requesting such information pursuant to RCW 34.05.320(3), and by sending notice to all registered electric and natural gas companies. Pursuant to the notice, the commission received comments from August 31 to September 7, 2018. The commission received written comments from Avista, Cascade, Northwest Natural Gas Company (NW Natural), PacifiCorp, PSE, The Energy Project, Kroger, AWEC, and public counsel.

14 On October 12, 2018, the commission issued a notice of technical workshop, and pursuant to that notice, held a workshop on December 3, 2018, to discuss draft rules, common topics for electric and natural gas cost of service studies, and service-specific topics for electric and natural gas cost of service studies.

15 On January 9, 2019, the commission issued notices of technical workshops. In Docket UE-170002, the notice indicated that the commission would hold a technical workshop for electric cost of service on February 21, 2019. In Docket UG-170003, the notice indicated that the commission would hold a technical workshop for natural gas cost of service on February 22, 2019.

16 On February 21, 2019, the commission held a technical workshop for electric cost of service, addressing the cost of service allocation methodology matrix filed in Docket UE-170002 on March 5, 2018, and discussing the methods used to calculate the functionalization, classification, and allocation factors related to: Generation; transmission; distribution; services; meters; customer service/billing; meter reading; and, administrative and general, general plant, and intangible plant.

17 On February 22, 2019, the commission held a technical workshop for natural gas cost of service, addressing the cost of service allocation methodology matrix filed in Docket UG-170003 on January 3, 2019, and discussing the methods used to calculate the functionalization, classification, and allocation factors related to: Distribution of mains; transportation main allocation; distribution assets; services; meters; customer service/billing; meter reading; and administrative and general, general plant, and intangible plant.

18 The February 21 and 22, 2019, technical workshops facilitated significant collaboration among participating stakeholders, and participants reached consensus for all but a few classification and allocation methodologies. Seeking to resolve the remaining methodologies, the commission determined that it should request that the investor-owned electric and natural gas utilities model and compare a variety of scenarios to help inform further collaboration among stakeholders and, ultimately, the commission's determination regarding whether the methodologies should be placed in rule.

19 On April 25, 2019, the commission issued a notice of informal draft rules for electric and natural gas cost of service and a notice of opportunity to file written comments due by June 14, 2019. The commission created several methodology "scenarios" for both electric and natural gas cost of service, and requested that each electric and natural gas utility hold all other factors constant during modeling and provide the results from each scenario along with any comments the utilities had on the informal draft rules.[3]

3 Due to confusion and editing errors regarding the requested scenarios, the commission revised and reissued the April 25, 2019, notice on May 6, 2019.

20 The electric methodologies lacking consensus, and therefore included in the requested scenarios, were generation classification, generation allocation, and transmission allocation. For generation classification, using the four coincident peak method for allocation, the commission requested that electric utilities model the following methods: Average and excess, fixed ratio methodology, renewable future peak credit (RFPC), thermal peak credit, and RFPC with net power costs accounts allocated based on energy. For generation allocation, using the average and excess method for classification, the commission requested that electric utilities model the following methods: Top 100/100 seasonal sales, load net of renewable generation, and the twelve coincident peak method. For transmission allocation, using the average and excess method for classification, the commission requested that electric utilities allocate costs in their modeling based upon transmission following generation and also upon applying the FERC method.

21 The natural gas methodologies lacking consensus, and therefore included in the requested scenarios, were distribution mains classification and distribution mains allocation. For distribution mains classification, the commission requested that natural gas utilities use the peak and average method for allocation to model system load factor, design day, and a hybrid design day. For distribution mains allocation, the commission requested that natural gas utilities use the system load factor method for classification to model commission staff's (staff) current method, staff's method proposed during the February 22, 2019, technical workshop, and design day.

22 The informal draft rules included with the April 25, 2019, notice contained draft amendments to WAC 480-07-510(6) and a draft new chapter under Title 480 WAC related to presentation and minimum filing requirements of cost of service studies, sources of data that must be used in a cost of service study, specific electric and natural gas methodologies that must be used in a cost of service study, and robust guidelines for what must be presented in any petition for exemption from the draft new chapter.

23 On April 30, 2019, the commission held a conference call to discuss with interested stakeholders any questions regarding the scenarios the commission requested the electric and natural gas utilities to model.

24 Between June 14 and August 2, 2019, the commission received comments from public counsel, Avista, AWEC, PacifiCorp, The Energy Project, Cascade, NW Natural, and PSE on the informal draft rules. To the surprise of the commission and several stakeholders, the results of the requested scenarios submitted by the electric and natural gas utilities showed negligible or no impact to a cost of service study from the selection of any particular methodology modeled.[4]

4 Of all the electric scenarios modeled and the three hundred thirty parity ratios provided, only twelve parity ratios from two of the scenarios resulted in outliers. These outliers resulted from the modeling of methodologies for heavily load-dependent classes. Based upon our understanding and the history of these methodologies as presented to the commission in adjudicated proceedings and rule makings, we find that the data and analysis provided in these dockets are not invalidated by these few inconsistent, outlier results from only two of the modeled scenarios. Regardless, we take into consideration all information and context provided in these dockets and, based on established principles and for reasons explained later in this order, select other methodologies than those that produced these outlier results.

25 On August 30, 2019, the commission issued a notice of workshop on September 25, 2019, for both electric and natural gas cost of service. Along with the August 30 notice, the commission included updated informal draft rules that incorporated comments and suggestions provided by stakeholders, a narrative and summary of the scenario results received from the electric and natural gas utilities, and, draft templates, entitled the electric cost of service template (ECOST) and the gas cost of service template (GCOST), that the commission intended to develop in compliance with the cost of service rules (proposed WAC 480-85-040) for standardizing presentation and submission of a cost of service study's results.

26 On September 25, 2019, the commission held a workshop with interested stakeholders and accepted written comments for both electric and natural gas cost of service. The commission sought discussion and comments addressing outstanding questions or concerns regarding the informal draft rules, discussing the generation, transmission, and distribution mains classification and allocation methods, per the results of the scenarios from the electric and natural gas utilities, and providing feedback on the commission's development of the ECOST and GCOST. In addition to the comments received at the workshop, the commission received written comments from September 25-27, 2019, from public counsel, Avista, PacifiCorp, PSE, and Cascade.

27 On October 11, 2019, the commission issued a notice of opportunity to file written comments by December 6, 2019, in which it sought further comment on the ECOST and GCOST templates. Public counsel, PSE, Avista, AWEC, NW Natural, and NW Energy Coalition (NWEC) filed written comments between December 5 and 12, 2019.

28 **SMALL BUSINESS ECONOMIC IMPACT ANALYSIS**: On August 30, 2019, the commission issued a small business economic impact statement (SBEIS) questionnaire to all interested persons. The commission received responses to this questionnaire on or about September 25, 2019, from Avista, Cascade, NW Natural, PacifiCorp, and PSE. Cascade, NW Natural, and PSE asserted in their responses that they are likely to incur increased costs from the proposed rule. However, none of the utilities qualify as small businesses under chapter 19.85 RCW. In addition, the proposed rules create requirements that are intended to streamline and thereby reduce the burden and costs borne in general rate cases by electric and natural gas utilities, other parties, and the commission. All costs to comply with the proposed rules, therefore, should be comparable to or less than the costs utilities and parties already incur during the adjudication of a general rate case before the commission. Thus, the commission has no evidence that any business will incur more than minor costs to comply with the proposed rules. Accordingly, no small business economic impact statement is required.[5]

5 *See* RCW 19.85.020 (2)-(3), 19.85.025(4), and 19.85.030 (1)(a).

29 **NOTICE OF PROPOSED RULE MAKING:** The commission filed a notice of proposed rule making (CR-102) on February 12, 2020, at WSR 20-05-033. The commission scheduled this matter for oral comment and adoption under Notice No. WSR 20-05-033 at 1:30 p.m. on April 16, 2020, in the commission's Richard Hemstad Hearing Room, located at 621 Woodland Square Loop S.E., Lacey, WA.[6] The notice provided interested persons the opportunity to submit written comments to the commission by March 27, 2020.

6 The commission conducted this rule-making hearing virtually, with telephonic or online participation, to conform to social distancing requirements related to the COVID-19 pandemic.

30 The CR-102 proposed streamlining amendments to WAC 480-07-510(6), which originally contained minimum requirements for the filing of a cost of service study in a general rate case. The development of a new chapter that more fully explains presentation, minimum filing, and methodological requirements for a cost of service study justifies streamlining this subsection to direct a company or party filing a cost of service study to the proposed rules for cost of service studies in chapter 480-85 WAC.

31 Proposed WAC 480-85-010 explains the purpose of the proposed new chapter. The proposed rules will streamline, improve, and promote efficiency in analyzing rate cases by clarifying presentations and prescribing preferred methods. While we require utilities and parties to constrain their cost of service study filings to the minimum requirements in these rules, we emphasize that the results of a cost of service study are only one basis upon which the commission establishes fair, just, reasonable, and sufficient rates. As has been the commission's precedent since the early 1980s, we do not mechanically apply the results from a given cost of service study.[7] Instead, we exercise our judgment, considering a variety of factors as appropriate, such as fairness, perceptions of equity, economic conditions in the service territory, gradualism, and rate stability when determining rate spread and rate design and establishing just and reasonable rates.

7 *In re Investigation into Rate Design and Rate Structures for Electrical Service, the Alterations, if any, that Should Be Ordered to such Rate Design and Rate Structures, and the Adequacy of Existing Rules Relating to Electrical Companies and Amendments or Additions Thereto that May Be Appropriate Regarding Master Metering, Information to Consumers, Advertising, and Termination of Service*, Cause No. U-78-05, Order 10-11 (Oct. 29, 1980).

32 The principle of streamlining processes is appropriate whenever the commission reviews its rules, including reviewing our rules governing cost of service studies for electric and natural gas utilities. Requiring a consistent presentation with minimum filing requirements will aid the commission, as well as other parties to a proceeding, to rapidly identify and evaluate key elements of the cost of service study. We recognize that this rule making will require utilities and parties to adapt to applying new requirements and using new forms for the presentation and submission of cost of service information, but after an initial period of adjustment, we have

confidence that the commission and the parties will reap the benefits of this new streamlined process.

33 Proposed WAC 480-85-020 states that the rules will apply to any person or party filing a cost of service study in any proceeding before the commission. The interrelation with the proposed amendments to WAC 480-07-510(6) clarifies that the *initial* filing of a general rate case should contain a cost of service study in compliance with proposed chapter 480-85 WAC. Any subsequent filing of a cost of service study by a party to a general rate case must also conform to the proposed rules in chapter 480-85 WAC.

34 Proposed WAC 480-85-030 defines certain cost of service terms. While there is broad consensus among stakeholders that the terms in the industry related to the cost of service field are well-developed and need not be defined in rule, the commission has observed small, but significant differences in how those terms are used by parties in proceedings. This section defines the terms in order to provide clarity throughout this chapter and guidance in proceedings for how these terms should be used. Codifying the definitions of certain terms in these rules will ensure that all persons and parties will uniformly understand key terms during commission proceedings, even if a term may have slightly alternate meanings within the industry. We suggest that any information intended by a utility or party not conveyed by these definitions should be clearly explained in testimony by express definition or by citing to an industry manual or other standard.

35 Terms of note within the definitions section include "common function" and "load study." The commission uses the term "common function" to refer to any particular assignment of costs when those costs can be assigned, at least in part, to both the electric and natural gas services of a dual-service utility. An example of such costs would be administrative expenses for billing. A "load study" provides a statistical analysis based on the sampling of actual usage from customers to inform a cost of service study. Understandably, customers' and customer classes' actual usage and the load study data derived therefrom evolves over time, which affects the relevance of the data used in a cost of service study. To ensure that data used in cost of service studies remain timely, current, and relevant, the commission adopts minimum standards of relevance. Initially, the commission used the definition of "load study" to convey this minimum standard by requiring that data not come from a load study conducted more than five years prior. After the CR-102 but before the adoption hearing, the commission updated the proposed rules as described further in paragraph 65, removing the last sentence from the definition of "load study" and modifying proposed WAC 480-85-050 for the purpose of more clearly conveying that data used in a cost of service study from any source must meet minimum recency requirements.

36 Proposed WAC 480-85-040 provides minimum filing requirements to ensure uniform presentation of cost of service studies. Minimum filing requirements requiring consistent presentation of cost of service studies will allow the commission and all parties to more easily identify and comprehend the issues parties raise in their cost of service studies. Under this proposed rule, all cost of service studies must be presented on the commission's cost of service forms for electric (ECOST) and natural gas (GCOST). The commission will ensure that the most updated version of these forms is posted to the commission's website for utilities and parties to use during a proceeding. The commission will continue developing these forms with stakeholder input as the commission and parties use the forms and identify any necessary improvements.

37 These minimum filing requirements are intended to streamline the presentation and evaluation of every cost of service study filed with the commission. To ensure that the commission and all parties benefit from these minimum requirements, proposed WAC 480-85-040(1) provides that presentations must include submission of testimony and exhibits supporting the cost of service study. No testimony or exhibits may reference any data, models, calculations, or other information used only in work papers unless the appropriate work paper is referenced and offered as an exhibit. Work papers must be provided to the parties to a proceeding to aid with verification and evaluation of a model's inputs and assumptions. When practical, the commission requires parties to include all calculations necessary to support the cost of service study's results in a single electronic workbook file. This requirement applies only to cost of service studies - not revenue requirement, rate spread, or rate design - although the commission encourages the consolidation and efficient assembly of all information presented in proceedings. Because cost of service workbooks and models may necessarily be numerous and difficult to navigate, the proposed WAC 480-85-040 (1)(b) requires each electronic cost of service workbook to have an index identifying links to any external spreadsheet. This index need not be more exhaustive than a list that clearly identifies external spreadsheets and to which tab and cell they are linked. Such an index would be unnecessary if all information were included in a single workbook.

38 Last, this section explains that for a dual-service utility, cost of service studies for a utility's separate services must be filed together.[8] It is possible, however, that a dual-service utility may file a general rate case for only one of its services. Under this circumstance, a dual-service utility need not file a cost of service for its other service (*i.e.*, an electric-only rate case must include a cost of service study for electric service, but not natural gas service). However, because there are certain expenses incurred by a dual-service utility that benefit both its electric and natural gas operations, a dual-service utility must consider these common costs and demonstrate their appropriate apportionment between electric and natural gas services. The burden of proof is on the utility to show that the apportionment of these common expenses is fair and just.

8 To ensure clarity and avoid redundancy, the word "simultaneously" was removed from this subsection, as explained in paragraph 66- **Error! Reference source not found.**

39 Proposed WAC 480-85-050 requires that a cost of service study's data must meet certain characteristics for granularity, whether from meter reads or from a load study. In these rules, the commission expresses no preference for any particular metering technology. "Advanced metering infrastructure" (AMI) and "advanced meter reading" (AMR) have definitions commonly understood within the industry,

but the commission does not limit "advanced metering technology" to those two types of advanced meters. Data from any kind of advanced metering technology may be used in a cost of service study provided the data's granularity meets or exceeds the rule's requirements of hourly data for electric and daily data for natural gas.

40 When a utility has advanced metering technology that meets or exceeds the granularity requirement, the commission expects the utility to use that data instead of using data from a load study. Accordingly, a utility with data meeting or exceeding the granularity requirement has the burden to explicitly justify use of data from a load study. Utilities with advanced metering technology meeting or exceeding the granularity requirement need not conduct a load study for customers who opt-out of the installation of advanced metering technology. Utilities without advanced metering technology, however, must conduct a load study and use data from a load study in a cost of service study.[9]

9 Data used in a load study cannot be older than five years pursuant to the proposed WAC 480-85-050.

41 Proposed WAC 480-85-060 specifies the methodology that must be used for a cost of service study. The commission requires that all cost of service studies filed with the commission be calculated using an embedded cost method with costs functionalized, classified, and allocated according to the methods outlined in Tables 1-4. The great majority of these methods are consistent with decades of commission precedent and were the product of compromise and broad consensus among the stakeholders involved in this rule making.

42 During this proceeding, the commission requested that utilities model scenarios for the classification and allocation methodologies that did not have broad consensus. The electric methodologies were generation classification, generation allocation, and transmission allocation. The natural gas methodologies were distribution mains classification and distribution mains allocation. As discussed above, the results of the scenarios revealed no or negligible differences between them. With input from the stakeholders, the commission selected methodologies for each of these classification and allocation methodologies based upon established principle. We discuss these methodologies and the supporting principles in more detail below.

43 For electric generation classification, the commission includes in the proposed rules renewable future peak credit (RFPC) with net power costs allocated on energy in the proposed rules. This method updates the peak credit method to rely on renewable generation resources instead of thermal resources. It also allocates net power costs solely based on energy. This is a suitable calculation when modern, renewable generation technologies have zero marginal cost and, therefore, do not contribute to net power costs accounts.

44 The renewable future peak credit method upholds a principle long-favored by this commission: A properly conducted cost of service study is forward looking by reflecting the purposes for which plant expenditures are made.[10] Innovation and public policy, *i.e.*, the Clean Energy Transformation Act (CETA),[11] will result in utilities relying on more than large, fossil-fueled plants for electricity generation. The renewable future peak credit method recognizes impacts on utility planning, including utilities' integrated resource plans (IRPs), and that requirements for generation sources other than those fueled by fossil fuels will lead to plant expenditures by utilities. Consistent with commission precedent and statutory guidance, we maintain the commission's forward-looking perspective and adopt, for the classification of electric generation, the RFPC method with net power costs allocated on energy.

10 *Wash. Utils. & Transp. Comm'n v. Wash. Water Power Co*., Cause Nos. U-82-10 and U-82-11 *(Consolidated)*, 2nd Supp. Order, 63-65 (Dec. 29, 1982) *(referencing In re Investigation into Rate Design and Rate Structures for Electrical Service, the Alterations, if any, that Should Be Ordered to such Rate Design and Rate Structures, and the Adequacy of Existing Rules Relating to Electrical Companies and Amendments or Additions Thereto that May Be Appropriate Regarding Master Metering, Information to Consumers, Advertising, and Termination of Service,* Cause No. U-78-05, Order, 7-11 (Oct. 29, 1980).

11 Chapter 19.405 RCW.

45 For electric generation allocation, the commission selects the following method in the proposed rules: "load net of renewable generation, using twelve coincident peaks (twelve CP); net power costs are allocated using annual energy usage at the point of generation." Renewable generation, principally in the form of nondispatchable and intermittent resources, does not follow the traditional cost-causation paradigm. Whereas fossil-fuel and hydro power resources have been freely dispatched to respond to load demands, renewable resources are, at least in the current system without widespread electricity storage and inverters programmed to support grid reliability, mostly binary and operate only when conditions permit. These resources are, therefore, used to offset load when they are available rather than being dispatchable to meet the load demands of the system. The system's demand remains a critical element of cost causation because energy is supplied in real time. To balance these competing components, the allocation of electricity generation costs should utilize load considerations, net of renewable generation, but only for the twelve highest individual demand points of the year (one from each month).

46 For allocation of electric transmission costs, the commission selects the twelve CP method in the proposed rules. Transmission infrastructure is critical for moving power to customers, including nonretail customers that receive electricity passed-through the utility's transmission network. Allocating transmission costs using the twelve CP method recognizes the importance of transmission pathways at their most critical moment, the peak hour, tempered by their use across the highest hour in each month. The need for transmission infrastructure to connect generation to load is necessary even in a modern electrical system where renewables are dispatched based upon their availability instead of the demands of a system's load. It is therefore appropriate to rely on federal standards for network access, which apportion the use of such a network in a manner consistent with both its operation and the planning requirements that lead to its construction.[12]

47 For natural gas distribution mains classification, the commission originally included in the proposed rules the phrase "system load factor." A utility's system load factor is used to determine how to allocate between demand and throughput. The commission, after receiving feedback and

comments on the natural gas distribution mains classification methodology, determined that the description "system load factor" was insufficient to clearly convey the commission's intent for this method. Because this classification methodology is interrelated with the allocation methodology of distribution mains, the most accurate term for the commission's intended terminology is "demand." This modification to the proposed rules is explained in greater detail in paragraphs 75-76.

48 For natural gas distribution mains allocation, the commission originally included "Design day (peak) and annual throughput (average) based on system load factor." The commission also determined that this description was insufficient to clearly convey the commission's intent in light of the clarifications made to the linked natural gas distribution mains classification method.

49 While the commission has historically rejected design day methodologies, the commission adopts design day in this rule making. The commission sees value in allocating the costs of distribution mains according to the intended design of the system. A core cost of service principle iterates that customers who can be directly assigned responsibility for a utility's costs to serve them should also be responsible for recovery of a utility's appropriate costs. The selected method for the allocation of natural gas distribution mains recognizes that a single customer class should be directly assigned the costs of distribution mains when practical. Additionally, where such assignments are not practical, the selected method's inclusion of the system load factor balances the use of the distribution mains with the cause of their construction. A component of distribution mains must be assigned to customers based on the quantity of gas that flows. Conversely, the timing of when that gas is most needed, such as the system peak, must also be recognized as a key cost driver for the construction of new distribution mains and the upgrades of existing ones. The commission, therefore, incorporates the use of design day, a calculation derived from a utility's integrated resource plan, in the cost causation framework. Accordingly, the commission determines that, where practical, distribution mains should be allocated by assignment to a single customer class, with all other costs being based upon design day and annual throughput based on system load factor. The modification to the language of this method is further explained in paragraphs 75 and 77.

50 In addition to an embedded cost of service study required by this section, proposed WAC 480-85-060(2) permit [permits] any party to also file a cost of service study based on a system-wide econometric study or a system-wide marginal cost study, both of which may provide greater granularity of data to inform the commission's cost of service decisions. In addition, the commission has amended this subsection to allow parties to file an additional cost of service study with modifications to any of the methodologies outlined in Tables 1-4. The burden of justifying those modifications is placed upon the proponent of the additional cost of service study in lieu of the burden of proof set forth in proposed WAC 480-85-070. This modification is consistent with the commission's original intent to allow an alternative cost of service study if a party petitioned for and received an exemption. This modification is further explained in paragraphs 67-72.

51 Proposed WAC 480-85-070 outlines the requirements for receiving an exemption from any part of chapter 480-85 WAC. Within this section, the commission reiterates its traditional exemption procedures (WAC 480-07-110) and also includes guidance regarding what information a party must submit with its petition to show that the requested exemption is "consistent with the public interest, the purposes underlying regulation, and applicable statutes."[13] Specifically, the commission intended to clarify that, to make such a showing for an exemption, a party must submit a cost of service study that complies with chapter 480-85 WAC and must provide a description of the circumstances under which the exemption for the alternate cost of service study should be granted.

13 *See* WAC 480-07-110(1).

52 After hearing feedback and comments from stakeholders on this section, the commission finds that the clarifications in the original exemption section are more appropriately transferred to proposed WAC 480-85-060(2). Additionally, the commission determines that the title of this section should mirror exemption sections in other chapters of commission rules and thus modifies the title. These modifications are further explained in paragraphs 67-72.

53 **WRITTEN COMMENTS:** The commission received written comments from public counsel, AWEC, Avista, PacifiCorp, PSE, Cascade, NW Natural, and NWEC. Staff's responses to those comments, which the commission adopts by this order, are contained in Appendix A, which is attached to, and made part of, this order, subject to the modifications we make to the proposed rules and the rationale for those modifications explained in this order.[14] Additionally, we summarize and respond in greater detail to certain comments received in writing and at the rule-making hearing in paragraphs 55-63, below.

14 In the event of any discrepancy between the rationale presented in this order and the responses contained in Appendix A, this order will control.

54 **RULE-MAKING HEARING:** On March 24, 2020, the commission issued a notice of virtual rule adoption hearing, requiring telephonic or online participation, finding good cause to conduct the rule-making hearing telephonically and online only due to social distancing requirements related to the COVID-19 pandemic. The commission considered the proposed rules for adoption at a rule-making hearing on Thursday, April 16, 2020, before Chair David W. Danner, commissioner Ann E. Rendahl, and commissioner Jay M. Balasbas. The commission heard oral comments from staff representatives Jason Ball, Elaine Jordan, and Elizabeth O'Connell. Representatives from PSE, AWEC, NW Natural, Cascade, public counsel, PacifiCorp, and NWEC also provided comments.

55 **SUGGESTIONS FOR CHANGES**: Stakeholder comments suggested many changes to the proposed rules. A summary of the suggested changes to the propose [proposed] rules submitted to these dockets and staff's proposed reasons for rejecting or accepting the suggestions are included in Appendix A. The commission adopts as its own the reasons proposed by staff for rejecting and accepting stakeholders' sug-

gested changes to the rules as proposed in CR-102 at WSR 20-05-033, subject to the modifications we make to the proposed rules and the rationale for those modifications explained in this order. Several of the suggested changes, which the commission rejects, warrant further discussion.

56 Several stakeholders expressed concerns about the methodologies selected in Tables 1-4 of proposed WAC 480-85-060(3). NWEC argues that the commission should reject the proposed rules and continue the rule-making process because the methods selected are unsuitable for the future of the electricity grid, which NWEC argues will require time-differentiated approaches to cost allocations. AWEC argues more specifically that the commission should modify the electric generation classification method to exclude the allocation of all net power costs to energy, and to require the presentation of a range of three methods for the natural gas distribution mains classification and allocation methods.

57 The purpose of the proposed rules is to increase efficiency in the presentation and evaluation of cost of service studies in general rate cases. As a preliminary matter, we decline to require the modeling of three different classification or allocation methods for natural gas distribution mains or any other functionalized cost. Such a requirement would be inconsistent with the purpose of this rule-making. Additionally, we find the presentation of three options for a classification or allocation methodology unnecessary considering the results of the modeled scenarios submitted by the Washington utilities in these dockets, which showed that there was no or negligible impact from the selection of any single methodology.

58 This rule making is the result of a three-year collaboration between various stakeholders and the commission, resulting in cost of service rules that include the requirements for certain methodologies to be used in a cost of service study. It is understandable, given the contentious history related to the selection of cost of service study methodologies in past proceedings, that several stakeholders strongly oppose the use of one methodology or another. This rule-making proceeding has progressed as a result of the extensive and open dialogue, as well as fair compromises made, by stakeholders and the commission, to the credit of all involved. We appreciate PacifiCorp's representative Meredith, who commented at the rule-making hearing that the rules, as a complete package, are reasonable and balance many of the diverse interests held by the stakeholders even if a stakeholder may not be completely satisfied with the selection of a particular methodology for one classification or allocation.

59 Meredith's example of such a balance directly addressed AWEC's proposal regarding the electric generation classification method. The electric generation classification method selected, RFPC with net power costs allocated on energy, is one that higher load factor customers, such as those represented by AWEC, may understandably find unsatisfactory or inappropriate when considered in isolation. On the other hand, an electric transmission classification method based entirely on demand is likely an outcome that higher load factor customers would fully support, at least when considered in isolation. The balance that is struck, therefore, is found in the selection of methodologies as a whole and not in piece.

60 In addition, higher load factor customers have been advocating for some time for the use of design day as the methodology for natural gas distribution mains. Since at least the early 1990s, the commission has found flaws with that proposal. In this rule-making proceeding, however, the utilities' modeling demonstrated the specific impact of altering a single methodology for natural gas distribution mains, holding all other factors constant. Specifically, the modeling identified that the difference between the use of design day and the other methods more commonly accepted by the commission was negligible or non-existent. Similar results were shown regarding the electric generation classification and allocation methodologies.

61 The classification and allocation methods selected, on the whole, are well-balanced among competing interests and reasonably consider the negligible impact any single method has on the results of a cost of service study. This balance permits the commission's cost of service evaluation in a general rate case to focus on the important and multifaceted justifications for accepting or adjusting the results of a cost of service study to effect [affect] rates that are fair, just, and reasonable, including factors that are appropriately argued by the parties through rate spread and rate design.

62 As stated above, the utilities' models for the electric generation classification and allocation methods provided results with no or negligible differences. We select the RFPC with all net power costs allocated on energy method because it updates the peak credit methodology to rely on renewable generation resources instead of thermal resources. This method better aligns the costs of generating resources used to supply electricity to ratepayers under the new paradigm mandated by the Clean Energy Transformation Act (CETA). Thus, we reject NWEC's argument that we are taking a step backwards with the selection of the classification and allocation methods in these rules. To the contrary, while arguments for time-differentiated approaches may be prescient of future needs, we find that the methodologies selected in the proposed rules are appropriate for regulation of current and near-future electric and natural gas service in Washington. As we explained earlier in this order, we will consider cost of service studies based upon different methodologies from those required by proposed WAC 480-85-060(3) when such methodologies are justified by new data, new circumstances, or new technology. We can assure all stakeholders that the commission will consider time-differentiated allocations, or some other new and system-appropriate method, when such methods materially improve the cost of service study and are in the public interest.

63 All comments submitted in the dockets over the past three years have been valuable and informative. At this time, however, we find that the selected methodologies in Tables 1-4 of proposed WAC 480-85-060(3) create an overall balanced approach that best serves the commission's consideration of whether rates charged to Washington customers are fair, just, reasonable, and sufficient. Accordingly, we find the methodologies we adopt in rule today are in the public interest, and do not accept the proposals to reject the proposed rules or to substantively modify the selected methods outlined in proposed WAC 480-85-060(3).

64 **CHANGES FROM PROPOSAL:** The commission adopts the proposal with the following changes from the text noticed at WSR 20-05-033. Some of these clarifying modifications were made after considering the responses received from stakeholders in written comments or in oral comments at the rule-making hearing.

65 The commission modifies proposed WAC 480-85-030(5) and 480-85-050 in order to clarify the age of data that may be used in a cost of service study. The commission deletes the last sentence of proposed WAC 480-85-030(5) regarding the definition of a "load study." The limitation that a cost of service study may not use data from a load study conducted more than five years prior is appropriate for *any* data, not just data from a load study. Data from advanced metering technology are readily available. While this should preclude the need for any explicit limitation on the recency of data from such technology, the commission finds that it is clearer and simpler to state the minimum requirement for the age of data relied upon, regardless of the source from which the data are derived. Accordingly, the commission adds a second subsection to proposed WAC 480-85-050, stating: "(2) Rate schedule usage data for any cost of service study must not be older than five years."

66 The commission modifies proposed WAC 480-85-040(2) in order to clarify for which service or services a dual-service utility must file a cost of service study in a general rate case. PSE included in its comments the suggestion that the word "simultaneously" be struck in order to avoid confusion as to how many cost of service studies a dual-service utility must file in a general rate case for only one of its services. In the event that a dual-service utility files a single-service general rate case, the subsection requires the justified apportionment of common expenses that are shared by both services for the purpose of acknowledging that some costs may be appropriately borne by customers of the service not subject to the rate proceeding. While we believe that the commission's original language in the proposed rules is clear that a dual-service utility need not file a cost of service study for both services if it files a general rate case for only one service, we agree with PSE that the word "simultaneously" should be struck from proposed WAC 480-85-040(2) as redundant. When a dual-service utility files a general rate case for both its services, the requirement already in rule assures that the cost of service studies will both be included in the initial filing. Accordingly, we strike "simultaneously" from proposed WAC 480-85-040(2).

67 Further, the commission modifies proposed WAC 480-85-060(2) and 480-85-070 in order to more clearly convey the intent to allow parties to file additional cost of service studies containing modifications to any of the methodologies outlined in Tables 1-4 of proposed WAC 480-85-060(3). The commission intends the proponent for any alternative cost of service study to bear the burden to justify any modifications to the methodologies outlined in Tables 1-4. Originally, the commission attempted to convey this burden through requiring parties to request an exemption from the rules pursuant to proposed WAC 480-85-070. In that section, the commission initially included language that stated both the commission's traditional exemption requirements and provided additional guidelines explaining how any party seeking an exemption should meet its burden to show the exemption is "consistent with the public interest, the purposes underlying regulation, and applicable statutes."[15] These guidelines required a petitioner for exemption to file a cost of service study that complied with proposed chapter 480-85 WAC, a cost of service study with the petitioner's modifications, and a description of the circumstances warranting the exemption. These requirements were intended to assist the commission evaluate [in evaluating] whether the petitioner's modifications provided any material improvements to the cost of service study required by proposed chapter 480-85 WAC and were, therefore, in the public interest and consistent with the purposes underlying regulation.

15 *See* WAC 480-07-110.

68 At the rule-making hearing, public counsel suggested that the requirement for a party [to] formulate testimony and exhibit supporting a cost of service study that deviated from the methodologies required by proposed chapter 480-85 WAC is too onerous when the party cannot anticipate whether its petition for exemption would be granted. According to public counsel, this would be inefficient for the petitioner and, if the petition is denied, would deprive the commission of information valuable for its determination of how a rate increase or decrease should be borne by customers. Public counsel argued that a party should be permitted to file an alternative cost of service study without seeking an exemption. AWEC echoed these concerns.

69 As with our response to NWEC's comments above, we disagree that the proposed rule would impact the commission's determination on the effect of rate increases or decreases on customers. First, rate spread and rate design determine how a rate increase or decrease is borne by customers. Cost of service studies produce results that help to inform rate spread and rate design, but the commission also considers many other factors, as appropriate in each case, including fairness, perceptions of equity, economic conditions in the service territory, gradualism, and rate stability. Limiting the parties' ability to use certain methodologies in their cost of service study - methodologies that the utilities' models during this rule making showed had no or negligible impact on the results of the cost of service studies - does not infringe upon the parties' ability to file testimony and exhibits supporting its recommendation for how the commission should consider the results of a cost of service study and other factors when determining rate spread and rate design.

70 We agree with public counsel, however, that requiring a party to prepare testimony and exhibit supporting an alternative cost of service study and petition for exemption, which the commission may deny, is an inefficient use of parties' and the commission's resources in a general rate case and may deprive the commission of information that may help inform its decision in the matter. We, therefore, remove the requirement that a party file a petition for exemption to present a cost of service study with modifications to the methodologies in proposed WAC 480-85-060(3). Instead, the commission will accept a party's cost of service study with modifications to the methodologies required by proposed WAC 480-85-060(3) *only in addition* to a cost of service study without any such modifications.

71 We emphasize that the purpose of these rules is to create efficiency for parties and the commission; allowing a party to file an additional cost of service study must not thwart this purpose. As with any proposal a party submits for commission consideration, the proponent of an additional cost of service study bears the burden of showing that each modification to the methodologies required by proposed WAC 480-85-060(3) materially improves the cost of service study and is in the public interest. A party must include a full explanation in its narrative testimony justifying each modification it proposes. This will include testimony that: Describes the extent of the modifications to the functionalization, classification, or allocation factors; provides the justification for the change in methodology, *i.e.,* new data, circumstances, technology, or other underlying conditions that have changed since the adoption of these rules; and explains any resulting shift in costs to a specific customer or customer class that cannot be addressed in testimony or evidence related to rate spread or rate design. Only with all of this information may the commission efficiently compare and contrast the party's modifications, and the justifications therefore, when evaluating whether to accept the party's modifications.

72 Accordingly, we strike the language that contained the additional guidance for what information the commission expected to receive in a petition for exemption in both subsections of proposed WAC 480-85-070 and replace it with language referencing the commission's established rule related to petitions for exemption (*see* WAC 480-07-110, 480-90-008, and 480-100-008). We add language to proposed WAC 480-85-060(2) to provide guidance for what the commission requires for presentation of a cost of service study that does not comply with chapter 480-85 WAC: Parties may file an *additional* cost of service study but must justify through narrative testimony each modification made to the methodologies in WAC 480-85-060(3) and explain in detail how each modification materially improves the cost of service study and is in the public interest.

73 The commission makes the following clarifying modifications to the methods outlined in Tables 1-4 of proposed WAC 480-85-060(3).

74 The commission modifies the language in Table 2 of proposed WAC 480-85-060(3) regarding the electric service lines allocation method to correct a typographical mistake. The commission intended the service lines allocation method to compare the average installed cost of a new service line (multiplied by customer count) to the total cost of the installed service line. A typographical error was made in the drafting of this allocation method, whereby average installed cost was compared to average installed cost. To correct this error and preserve the commission's intent, the second reference to "average installed cost" should be replaced with "total installed cost." Accordingly, the commission modifies the electric service lines allocation method in Table 2 of proposed WAC 480-85-060(3) to read "Average installed cost for new service lines multiplied by customer count relative to total installed cost."

75 The modern natural gas distribution system has existing infrastructure that undergoes new expansions. This infrastructure must continuously be evaluated to meet the needs of the expanding system, policy goals of the state, and day-to-day operating dynamics of real-time supply to customers. The appropriate cost drivers should, therefore, balance the plans that lead to construction of the infrastructure with the actual flow of gas. This understanding drives our selection of the classification and allocation methods for natural gas distribution mains.

76 The commission modifies the language in Table 4 of proposed WAC 480-85-060(3) regarding the natural gas distribution mains classification method to clarify the commission's intent. The method was originally expressed as "system load factor," which for a utility is used to determine how to allocate between demand and throughput. When the system load factor is used in the context of classification, there is no mathematical difference between using simply "demand" as the classification and continuing to allocate costs based on the system load factor. Cascade demonstrated this mathematical relationship in its comments, and proposed that the wording be updated to clarify that the classification method for natural gas distribution mains should be "demand." We agree. Cascade's proposed clarification produces the mathematical result intended by the commission, but more clearly applies cost of service principles. Accordingly, the commission modifies the natural gas distribution mains classification method in Table 4 of proposed WAC 480-85-060(3) to read "Demand."

77 The commission modifies the language in Table 4 of proposed WAC 480-85-060(3) regarding the natural gas distribution mains allocation method to clarify the commission's intent and maintain consistency with the modification to the natural gas distribution mains classification method. One principle of cost of service is assigning costs to a customer or customer class directly, where the costs can be directly attributed to that customer or customer class. It is not the commission's intent to change this principle and, as it applies to the allocation of distribution mains, we add language to clarify the commission's intent that distribution mains should be allocated to a customer class directly, where practical, with all other costs being allocated based upon design day and annual throughput based on the system load factor. The commission makes this clarification to maintain consistency with the natural gas distribution mains classification method. Accordingly, the commission modifies the natural gas distribution mains allocation method in Table 4 of proposed WAC 480-85-060(3) to read "Direct assignment of distribution mains to a single customer class where practical. All other costs assigned based on design day (peak) and annual throughput (average) based on system load factor."

78 The commission modifies the language in Table 4 of proposed WAC 480-85-060(3) regarding the natural gas distribution assets classification method to clarify the commission's intent and maintain consistency with the modification to the natural gas distribution mains classification method. The method was originally expressed as "demand," but after the modification to the natural gas distribution mains classification method it is appropriate to simply state that the classification method should follow distribution mains. Accordingly, the commission modifies the natural gas distribution assets classification method in Table 4 of proposed WAC 480-85-060(3) to read "Follows distribution mains."

79 The commission modifies the language in Table 4 of proposed WAC 480-85-060(3) regarding the natural gas distribution storage allocation method. AWEC and Cascade expressed concerns in their comments that the current language for the natural gas distribution storage allocation method would allow storage costs to be allocated to transport, or nonsales, customers. We disagree. Transport customers obtain their own gas supply and, therefore, do not rely on storage. The language already in rule specifies that only costs classified as balancing would be allocated to transport, or nonsales, customers. We find it appropriate, however, to clarify that costs other than balancing are not assigned to transport customers. Accordingly, the commission modifies the natural gas storage allocation method in Table 4 of proposed WAC 480-85-060(3) to read "Costs classified as balancing are allocated to all customers based on winter sales. All remaining costs are allocated to sales customers with a ratio based on average winter sales that exceed average summer sales."

80 Last, the commission makes typographical modifications to the title of proposed WAC 480-85-070 consistent with rule sections in other chapters that explain the requirements governing petitions for exemption.[16] Accordingly, the commission modifies the title of proposed WAC 480-85-070 to read "Exemptions from rules in chapter 480-85 WAC."

16 *See e.g.* WAC 480-90-008, 480-100-008.

81 **COMMISSION ACTION:** After considering all of the information regarding this proposal, the commission finds and concludes that it should amend and adopt the rules as proposed in the CR-102 at WSR 20-05-033 with the changes described in paragraphs 64-80, above.

82 **STATEMENT OF ACTION; STATEMENT OF EFFECTIVE DATE:** After reviewing the entire record, the commission determines that it should amend WAC 480-07-510(6) and adopt chapter 480-85 WAC to read as set forth in Appendix B, as rules of the Washington utilities and transportation commission, to take effect pursuant to RCW 34.05.380(2) on the thirty-first day after filing with the code reviser.

ORDER

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 7, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 7, 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.

THE COMMISSION ORDERS:

83 (1) The commission amends WAC 480-07-510(6) and adopts chapter 480-85 WAC to read as set forth in Appendix B, as rules of the Washington utilities and transportation commission, to take effect on the thirty-first day after the date of filing with the code reviser pursuant to RCW 34.05.380(2).

84 (2) This order and the rules set forth in Appendix B, after being recorded in the register of the Washington utilities and transportation commission, shall be forwarded to the code reviser for filing pursuant to chapters 80.01 and 34.05 RCW and chapter 1-21 WAC.

DATED at Lacey, Washington, May 27, 2020, and effective July 7, 2020.

Washington Utilities and Transportation Commission

David W. Danner, Chairman
Ann E. Rendahl, Commissioner
Jay M. Balasbas, Commissioner

Appendix A
Comment Summary Matrix

Appendix B
Amended and Adopted Rules

Cost of Service Rule Making
Dockets UE-170002 and UG-170003
Summary of Comments

This document summarizes all CR-102 comments the commission received regarding the cost of service rule making, Dockets UE-170002 and UG-170003.

CR-102 PHASE
COMMENTS FROM THE NOTICE OF OPPORTUNITY TO FILE WRITTEN COMMENTS ISSUED ON FEBRUARY 12, 2020

Stakeholder	General Comments Not Applicable to a Specific Section of the Rule	Staff Response
Avista	Avista appreciates the opportunity to provide comments. Avista has reviewed the proposed rule making referred to in this notice and the company is supportive of the proposed rules. However, the company is concerned regarding the amount of lead time necessary to fully implement the proposed rules.	Staff appreciates Avista's comments and work on the proposed rules.

Stakeholder	General Comments Not Applicable to a Specific Section of the Rule	Staff Response
	The company believes a transition period of up to one-year for the complete implementation of these rules upon passage would be reasonable.	Staff understands the concerns of stakeholders about implementation and will ask that the commission take it into consideration.
NW Natural	Reviewed the proposed rules and does not have any other comments or proposed revisions beyond what has already be [been] provided to the docket.	Staff appreciates NW Natural's earlier comments and work on the proposed rules.
NWEC	We are disappointed that none of our concerns are addressed in the final draft, nor have we been provided any explanation as to why they were not accepted. Our concerns that the rules are not adequate for the current or future utility regulatory system remain. In essence, costs of assets that are used for many hours in broader peaks should be assigned to the hours when those assets are providing service regardless if those hours are peak or nonpeak hours, not just to twelve coincident peaks a year. Likewise, assigning distribution substation costs based on seasonal averages (after large customer portions are calculated), exempts some customers from any responsibility for costs; better to directly apportion costs on a time differentiated energy basis to all customer classes, which will ensure that customers using those assets at high-demand periods will pay an appropriate amount. The current draft of the cost allocations looks backward to a system that is fast disappearing and needs to be able to adapt to a rapidly changing electrical system.	Staff appreciates NWEC's comments and will continue to respond to those comments that have been received in a timely manner. Staff respectfully disagrees with NWEC that the proposed rules are "not adequate for the current or future utility." The proposed rules provide an appropriate balance between the cost drivers of the existing system and the potential for new requirements. In addition, the proposed rules allow for parties to present an alternative through a petition for exemption that is consistent with the public interest, the purposes of underlying regulation, and applicable statutes.
PacifiCorp	PacifiCorp fully supports the proposed rules as they are currently written. Additionally, PacifiCorp has experienced a smooth transition in implementing these rules with the cost of service study it filed in its current general rate case.	Staff appreciates PacifiCorp's previous comments and work on the proposed rules.
PSE	PSE is concerned that the current draft rules are being proposed and established in a silo, and do not sufficiently take into consideration the possible outcomes from other proceedings such as the notice of inquiry into the adequacy of the current regulatory framework employed by the commission in addressing developing industry trends, new technologies, and public policy affecting the utility sector, Docket U-180907.	Staff respectfully disagrees with PSE that the proposed rules "do not sufficiently take into consideration the possible outcomes from other proceedings." The proposed rules provide an appropriate balance between the cost drivers of the existing system and the potential for new requirements. In addition, the proposed rules allow for parties to present an alternative through a petition for exemption that is consistent with the public interest, the purposes of underlying regulation, and applicable statutes.
Comments affecting WAC 480-85-030 Definitions		
(1) Allocation Factor		
Stakeholder	**Summary of Comments**	**Staff Response**
Public counsel	Public counsel recommends the following definition for allocation factor: "Allocation factor" means the customer class (or rate schedule) percentage contribution to the total utility amount of a particular attribute used to allocate jointly-incurred costs.	Staff believes that the proposed definition is sufficiently broad and therefore already includes the elements public counsel is proposing.
(2) Common Function		
Stakeholder	**Summary of Comments**	**Staff Response**
PSE	The term "Common function" is defined as "costs that can be functionalized to both electric and gas operations." While PSE agrees with this definition, it should be noted that the term "Common function" can be confused with common functionalization methodology in WAC 480-85-060 Cost of service methodology.	Staff respectfully disagrees with PSE that the definition for "Common function" can be interchanged with the common functionalization methodology. "Common function" is abbreviated to "Comm" in the appropriate sections thereby eliminating any potential confusion.
(3) Cost of Service Study		
Stakeholder	**Summary of Comments**	**Staff Response**

PSE	"Regulatory accounting rules and principles" is used in the definition for 'cost of service study,' however it remains unclear which accounting rules and principles are being referenced. PSE recommends adding additional language that clarifies which regulatory accounting principles are being referenced.	Regulatory accounting rules and principles are well understood industry terms that appropriately describe the commission's regulatory practice and evaluation of matters before it. Staff believes this additional language is therefore unnecessary.
Public counsel	Public counsel recommends the following definition for "cost of service study": "Cost of service study" means an embedded study that allocates revenues, operating income, and rate base items to individual customer or rate classes based on direct assignment where practical. Costs are allocated based on cost causative factors to the extent that such cost causative factors can be identified and quantified or allocated based on what can be considered fair and reasonable.	Staff believes the proposed definition is sufficiently broad, and therefore already includes the elements public counsel proposes.
(5) Load Study		
Stakeholder	**Summary of Comments**	**Staff Response**
Cascade Natural Gas	Throughout the course of this rule-making docket Cascade has taken the reasoned position that the gas load research study of the type described in the proposed by the draft rules does not represent an improved and cost-effective approach to determining class level design day peak demands for use in a gas utility's COSS. First, notwithstanding the significant cost, potential program pitfalls and data weaknesses alluded to earlier that load research studies may encounter, adequate consumption data already exists in years of monthly billing records for the entire population of Cascade's core customer classes, from which statistically sound regression analysis results are currently produced on an ongoing basis. This load data provides reliable class level design day peak demands for use in the COSS, which more than adequately meets the gas utility industry definition of a "load study."	Staff respectfully disagrees that load studies that rely solely on monthly billing records will result in a statistically sound analysis. Specifically, input data that reflects actual daily usage during the course of a month is superior to estimates developed for that purpose.
PSE	The requirement to conduct load studies every five years can be interpreted in multiple ways. One could interpret it as meaning the need to design and select a new sample and perform a load study for a minimum of twelve months, every five years, or it could be interpreted to mean that one could have a sample that is in place for ten consecutive years and that would comply. PSE recommends further clarification on the selection of sample set.	Staff agrees with PSE's comments and will ask the commission to incorporate minor, nonsubstantive revisions to address this concern.
Comments affecting WAC 480-85-040 Minimum filing requirements		
Subsection (1) All cost of service study results must be filed in the following forms, available from the commission: Electric cost of service template; and, gas cost of service template…		
Stakeholder	**Summary of Comments**	**Staff Response**
PSE	Subsection (1)(a): Draft rules include a new minimum requirement to cite work papers in supporting testimony and exhibits. Work papers are already provided to support testimony and exhibits. Further, testimony and exhibits do not typically cite to work papers, as they are excluded from the evidentiary record. PSE is concerned with creating an unnecessary and duplicative requirement that only overloads the testimony and exhibits as well as forces an overly burdensome procedure on all parties. Moreover, this draft rule unnecessarily duplicates WAC requirements that already exist for utilities to provide all of their spreadsheet exhibits with live links to any associated workpapers.	The purpose of this requirement is to reduce regulatory burden on parties reviewing a proposed cost of service study. The requirement exists only where testimony references or relies upon information not already found in other testimony or an exhibit. Staff therefore disagrees that the requirement will result in an "overly burdensome procedure" as all data, models, and calculations referenced in testimony should be provided to ensure the record in a general rate case is complete and satisfactory for commission review.

	Subsection (1)(b)(i): The new minimum requirement in this subsection where 'all associated calculations necessary to support the results of the study must be consolidated in the same electronic workbook file' may not be feasible. Taken to its extreme, this could entail the consolidation of what is currently approximately one hundred spreadsheets (many with a dozen or more individual tabs) into a single workbook file. PSE recommends ring-fencing the subsection to only include the cost of service model, excluding revenue requirement and rate design spreadsheets. If the intent is to have this requirement only apply to the cost of service model, then adding appropriate language to explain this is recommended. Additionally, it is unclear if Microsoft Excel could even accommodate the volume of resulting data and calculations, and whether a typical computer could process a file that large. PSE recommends to allow for flexibility in this requirement.	Staff understands PSE's concern. This rule making, however, pertains only to cost of service study requirements. The proposed language specifically references "models" or "cost of service workbook" in subsections (i), (ii), and (iii). Further, (i) specifically notes that the requirement to consolidate workbooks into a single file exists only wherever practical. Staff therefore disagrees that such requirements are overly burdensome or unclear.
Public counsel	Proposed WAC 480-85-040(1) refers to electric cost of service templates and gas cost of service templates, and the proposed rule requires all cost of service studies to be filed using the template forms. Templates for both electric and natural gas were shared with stakeholders on October 11, 2019. Several of the utility stakeholders raised questions or proposed revisions to the templates. The templates were not circulated with the most recent notice of opportunity to file written comments, so the final templates are unknown. If the templates have been modified, it may be useful to circulate them for additional stakeholder review and comment.	Staff will continue to work with parties to develop appropriate templates that are available through the commission's website.
Subsection (2) Companies that provide electric and natural gas service must file a cost of service study for their electric and natural gas operations simultaneously. If a company providing electric and natural gas service files a general rate case for only one of its services, the company must apportion the common costs shared by both services in lieu of filing a cost of service study for the service not included in the general rate case.		
Stakeholder	**Summary of Comments**	**Staff Response**
PSE	Subsection (2): The new minimum requirement in this subsection appears to require companies to jointly file for electric and gas rate cases. This is not currently required in any of the other commission rules. If this is not the staff's intent, PSE recommends striking the term "simultaneously" in the end of the first sentence.	The rule does not require a company to jointly file electric and gas rate cases as explained in the latter half of subsection (2). However, staff agrees that PSE's proposed revision will enhance the rule's clarity. Staff will ask the commission to incorporate the proposed revision as a minor, nonsubstantive modification.
Comments affecting WAC 480-85-050 Cost of service study inputs		
Subsection (1) The rate schedule usage data for any cost of service study must come from the best available source: Advanced metering technology, including advanced metering infrastructure (AMI), and advanced meter reading (AMR), or a load study.		
Stakeholder	**Summary of Comments**	**Staff Response**
Avista	The company does not believe that conducting an expensive new load study prior to the completion of its AMI meters project, likely by a third-party entity, would be a prudent use of resources for customers to incur given the imminent availability of the AMI data. The company asks that there be flexibility in this type of situation as the company completes its transition to full deployment of AMI meters.	Staff understands the concerns of stakeholders regarding implementation and will ask the commission to take that into consideration.

PSE	Subsections (1) through (4): The new rule appears to favor usage data in the following order: AMI, AMR, and load study. PSE is concerned the draft rules, as written, confuse the difference between metering technology and load research process. AMI and AMR are metering technology and infrastructure that allow for collection of meter data to support a load study. A load study is an analysis that measures and studies the characteristics of electric or gas loads to provide a statistically significant estimate of usage, trends, and general behavior of the load characteristics of the service company customers. If the intent is to develop load study results using the full customer population data in lieu of a sample set for the cost of service study, this should be explicitly stated. PSE is concerned with the confusion in this section between metering technology and the process to develop cost of service study inputs as well as the rigid preference to use full population data due to the following reasons: i. The minimum requirement to use hourly data for electric and daily data for gas would sum to nearly ten billion data points for a single PSE test year. Using this massive volume of data for the cost of service study would be resource intensive and impractical, especially given that the use of sample sets has successfully provided statistically significant estimates of load profiles/shapes required for the cost of service study. ii. This section states a preference to use actual usage data and to only use load study data if AMI/AMR data is not available. Even if full population data collected from AMI/AMR is used, a load study is still required to conduct statistical analysis on the full population data set to develop the usage inputs applied in the cost of service model. iii. AMI data is not perfect or one hundred percent available. Often, AMI meter reads may be partial, incomplete, missing or corrupted, requiring some element of VEE of the AMI data. As the draft rules are currently written, it is unclear if the VEE process, which is an industry standard process used for cleansing data, would be allowed. iv. All customers within a customer class or rate schedule may not have metering technology to allow for hourly/daily meter reads, thereby necessitating the need for some element of estimation of usage, trends and general behavior of load characteristics to develop load profiles/shapes of customers. v. AMI/AMR data for gas is measured in CCF and is converted to therms for billing purposes. As the draft rules are currently written, it is unclear if PSE's current practice of using therms within the COS study would be allowed. vi. This section indicates a preference for using actual peak day over design day for gas cost of service input. It is unclear, what impact this section would have on the use of design day peak loads based off a load study for the distribution mains allocation methodology specified in Table 4. As currently proposed, PSE cannot support this language as it prescribes or favors only AMI and AMR technology as the preferred method for meter data collection, and disallows the use of MV-90, PowerSpring, other analog meters, load forecasts, contract demands, as well as normalization and other statistical techniques normally used to develop inputs for a cost of service study (such as the estimate of energy consumption under normal weather conditions or the estimate of "design day" peak demands under more extreme weather conditions).	Staff respectfully disagrees with PSE. AMI and AMR are broad industry terms that are not specific to one form of metering technology. Further, the proposed rules include AMR and AMI as a subset of any "advanced metering technology." The rule does not state any preference between the respective technologies. Instead, the rule requires data collected through any metering technology to meet certain granularity requirements. These rules do not replace the use of sampled data for a full population in a statistical analysis. Rather, staff is interested in the use of granular input data that reflects sub-monthly data during a month. Such data is far superior to estimates. These rules do not preclude "cleaning" data sets, which is a necessary step in any statistical analysis.

Public counsel	This proposed provision conflicts with certain natural gas proposed rules. Specifically, proposed WAC 480-85-060 Cost of service methodology (Table 4) requires demand (load) to be allocated based on "Design Day." Design day demands are based on econometric analysis, not load studies. The cost of service methodology in proposed WAC 480-85-060 (Table 4) requires the use of econometric analysis. Estimations are therefore required in natural gas cost of service studies.	Staff respectfully disagrees. The requirement to use data from advanced metering technology or a load study does not preclude the use of design day as an allocation methodology. Neither does the allocation based upon design day for distribution mains undermine the requirement that cost of service studies be based on data as specified in WAC 480-85-050(3). The commission is concerned that the use of econometric analysis in this context will allow utilities to not study certain aspects of actual usage. Staff respectfully disagrees that load studies that rely solely on monthly billing records will result in statistically sound analysis. Specifically, input data that reflects actual daily usage during the course of a month is superior to estimates developed for that purpose.
Comments affecting WAC 480-85-060 Cost of service methodology		
Subsection (1) A cost of service study filed with the commission must be calculated using an embedded cost method.		
Stakeholder	**Summary of Comments**	**Staff Response**
PSE	Subsection (1): This subsection strictly adheres to traditional forms of regulation by prescribing a cost of study using an embedded cost method. While this is common practice today, particularly with ongoing discussion on alternative forms of regulation, it may restrict the commission to use only traditional approaches to cost allocation. PSE is concerned that the current rules are being proposed and established in isolation, and do not take into consideration the possible outcomes from other proceedings.	Please see response to PSE's general comments.
	Subsection (1)(a)-(e) and (3): PSE appreciates the need to codify uniform classification and allocation methodology for the development of a cost of service study. PSE generally supports such rules for transmission, distribution and general functions. However, PSE questions whether it is appropriate to codify rules for classification and allocation of generation in a time when the electric industry, utility generation portfolios, and the regional energy and capacity markets are in a state of flux. Prescribing methodology that is likely to be obsolete in a couple years will limit our ability to respond to changing conditions and may generate inaccurate cost assignments. PSE strongly recommends the rules exclude the classification and allocation of generation for the time being due to the rapidly changing energy markets and utility generation portfolios.	Please see response to PSE's general comments.
	Subsection (1)(e): It is unclear whether "Comm" is an abbreviation meaning the common function or common functionalization method. PSE recommends further clarifying the abbreviation.	"Comm" is clearly defined as an abbreviation for the "Common Function." No additional clarification is needed.
Subsection (2) In addition to filing a cost of service study as required in subsection (1), a party may file a cost of service study based on a system-wide econometric study or a system-wide marginal cost study.		
Stakeholder	**Summary of Comments**	**Staff Response**
PSE	Subsection (2): PSE recommends defining the terms "system-wide econometric study" and "system-wide marginal cost study" within the definitions section of the rules.	Staff does not believe these definitions should be incorporated into the proposed rule at this time since these rules do not differ from their plain meaning known in the industry.
Subsection (3) - Tables 1 - 4 of this subsection outline the functionalization, classification, and allocation methods required by subsection (1).		
Stakeholder	**Summary of Comments**	**Staff Response**

PSE	Subsection (1)(a)-(e) and (3): PSE appreciates the need to codify uniform classification and allocation methodology for the development of a cost of service study. PSE generally supports such rules for transmission, distribution and general functions. However, PSE questions whether it is appropriate to codify rules for classification and allocation of generation in a time when the electric industry, utility generation portfolios, and the regional energy and capacity markets are in a state of flux. Prescribing methodology that is likely to be obsolete in a couple years will limit our ability to respond to changing conditions and may generate inaccurate cost assignments. PSE strongly recommends the rules exclude the classification and allocation of generation for the time being due to the rapidly changing energy markets and utility generation portfolios.	Please see response to PSE's general comments.
Table 1 - Electric Cost of Service Approved Functionalization Methodologies		
Stakeholder	**Summary of Comments**	**Staff Response**
NWEC	NWEC proposes several changes to the accounts identified in FERC 1, primarily related to usage.	Staff respectfully disagrees with NWEC that these accounts are usage related. Commission precedent on these issues has been clear.
PSE	The term "Common function" is used interchangeably between "Common function" and common functionalization method. PSE recommends changing the term for common functionalization method to 'General,' 'Administrative & General,' or 'A&G.' PSE suggests the addition of several FERC account numbers to the functionalization categories.	"Comm" is clearly defined as an abbreviation for the "Common Function." No additional clarification is needed. Staff believes the commission should decline to include additional FERC accounts in the proposed rule. In addition, WAC 480-85-060 states FERC accounts not explicitly included in these rules may be functionalized on a utility-by-utility basis and must be identified and supported through testimony.
Public counsel	The primary concern public counsel has with Tables 1 and 3 is that the requirement to explicitly functionalize each cost component is unnecessarily burdensome and provides no additional useful information. Functionalization is not typically contentious, and the FERC Uniform System of Accounts provides general functionalization of individual accounts. Public counsel continues to question the need for Tables 1 and 3 and supports removal of those tables.	Staff respectfully disagrees that these tables are unnecessary. They provide clear guidance on a core element of cost of service studies to utilities and stakeholders.
Table 2 - Electric Cost of Service Approved Classification and Allocation Methodologies		
Stakeholder	**Summary of Comments**	**Staff Response**
AWEC	*Generation:* AWEC does not oppose the use of the renewable future peak credit method. When allocating costs between demand and energy under this method, however, AWEC recommends that all generation costs, both fixed and variable costs, be treated identically. As used today, the peak credit method allocates all production costs, including net power costs, based on a demand/energy split. AWEC recommends a similar application for the renewable future peak credit method. *Distribution:* Where practical, AWEC is supportive of directly assigning costs to large customers. Notwithstanding, if a large customer is directly assigned the cost of its distribution facilities, it would be inequitable for additional system costs to be indirectly assigned on the basis of the large same customer's distribution system coincident peak, or other rolled-in factor. Doing so will over-allocate costs to the customer because the customer would be paying for one hundred percent of its own distribution costs, plus a rolled-in portion of the other customers' costs as well.	RFPC relies on the difference between a renewable energy generation resource and a storage resource while the traditional peak credit method relies upon the difference between a natural gas peaker and baseload resource. Because the RFPC relies upon resources that do not normally contribute to net power costs, it is inappropriate to allocate net power costs in a similar manner. Therefore, staff believes the commission should decline to incorporate net power costs into the allocation of fixed generation costs. The rules prohibit assigning any similar remaining costs in an account to classes already included in the direct assignment of those costs. Staff believes that additional clarity is unnecessary.

NWEC	NWEC proposes "Time-differentiated energy" because the only costs that should be allocated based on peak demand are the costs of demand response involved during those peak hours. All other assets are used for much broader peaks, and the costs should be assigned to all hours when the assets are providing service. Further, transmission should not be allocated based on demand. Transmission is build [built] to deliver bulk power. Transmission costs should be allocated to the hours when transmission assets are utilized. If they are mostly utilized in off-peak hours, the costs should follow the benefits into those hours. Regarding distribution poles and wires, NWEC again proposes "Time-differentiated energy" since the proposed method has the effect of providing favorable treatment to some customers. This direct assignment could be applied to all customer classes, on a substation by substation basis. Some substations are sized to summer loads (irrigation), some are sized to winter loads. This type of allocation proposed here limits the parties from proposing cost-based allocation of these costs where the "average of summer and winter" are not reflective of relevant costs. Apportionment of these costs on a time-differentiated energy basis will ensure that customers using them at high-demand periods will pay an appropriate amount. Basing allocation on demand exempts some customers (using off-peak energy) from any responsibility for costs.	Staff respectfully disagrees with NWEC that demand or distribution is driven solely by time. It appears that the information NWEC requests the commission to consider is chiefly related to the fundamental design of rates, which is beyond the scope of this rule making and more appropriately addressed elsewhere.
PSE	Generation Classification Method: Commission staff's proposed renewable future peak credit with net power costs allocated on energy (RFPC) is not defined, nor is a calculation for the method provided in the draft cost of service rules. As the method is untested and unprecedented, PSE strongly questions whether this classification method should be included in the rule making. If the commission finds that RFPC is appropriate to use for electric classification, PSE strongly recommends the commission provide clear guidance and rules with its use. Defining parameters and how the classification method should be calculated before inclusion in the rule making are essential, since the RFPC is not a standard classification method that has been tried and tested, thus lacking case precedent in addition to the following:	Staff disagrees with PSE's comments. The renewable future peak credit method uses industry accepted norms for evaluating demand and energy components (similar to the peak-credit method) but incorporates new types of generation that were not available when the "industry accepted" methods were created. Introducing new generation types to classification of energy and demand is consistent with the underlying changes in a utility's portfolio while recognizing the existing fleet of investments that provide service to customers. The name "renewable future peak credit" merely helps to describe the incorporation of these new types of generation into the industry-accepted peak credit method. Further, the utilities helpfully submitted to this docket the resulting information from a cost of service study using this methodology.
	PSE recommends removing 'annual' in the second sentence so it reads 'Net power costs are allocated using energy usage at the point of generation.' Including the term 'annual' in the sentence would run counter to time-of-use pricing. Removing the term allows flexibility for allocating costs.	
	Service Lines Allocation Method: PSE questions if the allocation method should read 'average installed cost for new service lines multiplied by customer count relative to total installed cost.'	Staff agrees with PSE's comment and will ask the commission to incorporate minor, nonsubstantive revisions to address these concerns.
	Administrative & General and General Plant: PSE recommends the remainder of administrative and general and general plant costs also be allocated on standardized methods. Quite often disagreements continue to arise on cost allocation methods that have an immaterial impact on the cost of service study results. PSE is indifferent on the methods used to allocate the remainder of administrative & general and general plant costs.	Staff believes that the commission should decline at this time to direct utilities to apply a specific method to administrative and general or specific factors for intangible plant because there can be significant variations amongst the structure companies use to manage their operations, especially for IT-related projects.
	Intangible Plant Allocation Method: PSE seeks clarification on which appropriate factors to use to allocate intangible plant. Quite often disagreements continue to arise on cost allocation methods that have an immaterial impact on the cost of service study results. PSE is indifferent on the methods used to allocate intangible plant.	Staff believes that the commission should decline at this time to direct utilities to apply a specific method to administrative and general or specific factors for intangible plant because there can be significant variations amongst the structure companies use to manage their operations, especially for IT-related projects.

Table 3 - Natural Gas Cost of Service Approved Functionalization Methodologies

Stakeholder	Summary of Comments	Staff Response
Avista	The cost of service methodology proposed in WAC 480-85-060 for natural gas demand costs calls for allocation by design day peak demand. Considering that design day peak demand is a planning estimate independent of actual test period daily usage, the company finds WAC 480-85-030(5) load study performed at a minimum every five years or WAC 480-85-050 advanced metering daily load data requirements to be superfluous if the design day peak demand methodology is adopted into rule.	Staff understands Avista's concerns. However, staff respectfully disagrees that design day cannot be informed by load studies that incorporate statistically sound analysis. Specifically, input data that reflects actual daily usage during the course of a month is far superior to estimates developed for that purpose.
AWEC	While AWEC does not have comments on the approved functionalization methodologies in Table 3, AWEC suggests that the table be organized to distinguish between plant accounts and expense accounts.	Staff appreciates AWEC's comments but believes the commission should decline to incorporate these changes. FERC designates which accounts are expenses and which are plant accounts. Therefore, staff believes repeating the designations here is unnecessary.
Cascade	The "Stor" function should include electric to account for utility scale battery or other electricity storage technologies [that] are employed on the utility's distribution system. In addition, Cascade proposes account numbers for Liquified Natural Gas (LNG) Terminaling and Processing Plant, and Operation and Maintenance (O&M) expenses.	Staff believes that the commission should decline to address the specific method for functionalizing electricity storage at this time because such costs are natively captured through generation and distribution. The commission has authority to consider this addition whenever the technology and industry mature to the point where such treatment is warranted. Staff believes that the commission should decline to include additional FERC accounts in the proposed rule. In addition, WAC 480-85-060 states FERC accounts not explicitly included in these rules may be functionalized as a utility sees fit and must be identified and supported through testimony.
PSE	PSE suggests the addition of the several FERC account numbers to the functionalization categories.	Staff believes that the commission should decline to include additional FERC accounts in the proposed rule. In addition, WAC 480-85-060 states FERC accounts not explicitly included in these rules may be functionalized as a utility sees fit and must be identified and supported through testimony.
Public counsel	The primary concern public counsel has with Tables 1 and 3 is that the requirement to explicitly functionalize each cost component is unnecessarily burdensome and provides no additional useful information. Functionalization is not typically contentious, and the FERC Uniform System of Accounts provides general functionalization of individual accounts. Public counsel continues to question the need for Tables 1 and 3 and supports removal of those tables.	Staff respectfully disagrees and believes these tables: (1) Provide clarity to companies and stakeholders, (2) help ensure consistency among studies, and (3) reduce the commission's administrative burden during evaluation.

Table 4 - Natural Gas Cost of Service Approved Classification and Allocation Methodologies

Stakeholder	Summary of Comments	Staff Response
AWEC	While AWEC supports the use of Design Day Demand (peak) rather than an averaging of peak days for allocating the demand classified component of main costs, AWEC still believes that the classification of mains as both demand related and throughput related unfairly allocates costs to high load factor customers. Accordingly, for Distribution Mains, Transmission Mains and Distribution Assets, AWEC suggests that Table 4 be revised to provide for three class cost of service studies to provide a range of results—Design Day Demand (peak), Average and Excess, and Peak and Average. This would provide more information to the commission which it could use as the basis for determining the allocation of costs to customer classes.	Staff believes that the commission should decline to require utilities to provide three separate cost studies. Tripling the amount of work and resources used by utilities prior to filing, by stakeholders in response, and by the commission in its evaluation, would not produce an associated benefit of sufficient value. Rather, such a process would thwart a purpose of this rule, which is to reduce the administrative burden on all involved. Additionally, the information gleaned from the presentation of multiple studies would offer little additional value when the commission applies the results of the cost of service through rate spread and rate design.
	Storage: For storage costs, it was AWEC's understanding that only system balancing costs would be allocated to all customers, because this benefits all customers. However, it was also AWEC's understanding that the remaining costs would be allocated to sales customers only because only sales customers benefit from storage gas. The proposed rule on storage is ambiguous as drafted. AWEC would suggest inserting phrase "Sales Customers" as follows: "All remaining costs are allocated to sales customers with a ratio based on average winter sales that exceed average summer sales."	The rules are clear as written, but staff agrees with AWEC's comment that the rules would benefit from the additional clarity as proposed and will ask the commission to incorporate minor, nonsubstantive revisions as appropriate.

Cascade	*Distribution Mains:* Clarification is needed that distribution mains are classified as demand; and the system load factor is the basis for the split of costs at the allocation step between Design Day and Annual Throughput.	The rules are clear as written, but staff agrees with Cascade's comment that the rules would benefit from the additional clarity as proposed and will ask the commission to incorporate minor, nonsubstantive revisions as appropriate.
	Storage: Clarification is needed that costs classified as balancing are allocated to all customer classes based average daily injection/withdrawal experience throughout the year in the storage reservoir.	The rules are clear as written, but staff agrees with comments from AWEC, above, and will ask the commission to incorporate minor, nonsubstantive revisions which address Cascade's concern.
PSE	*Distribution Mains:* Allocation methodology specifies "Design day (peak) and annual throughput (average) based on system load factor." PSE is unclear whether this rule would allow the use of main pipe diameter to allocate costs to some customer classes but not others. Additionally, would this rule allow direct assignment of costs to some customer classes but not others (e.g., special contracts)? PSE recommends further clarification for this allocation method.	The rules are clear and do not allow for the use of main pipe diameter to allocate costs to some classes but not others. Special contracts are not required to be included in an embedded cost study and can be addressed on a utility-by-utility basis in a GRC.
	Distribution Assets: PSE is unclear whether the allocation methodology should be "Demand," as specified, or "System load factor" per "Follows distribution mains" consistent with Distribution and Transmission Mains functionalized category? PSE recommends further clarification for this allocation method.	The rules are clear as written, but staff will ask the commission to incorporate minor, nonsubstantive revision based on Cascade's comments above. Since these two components are linked, the clarification should also resolve PSE's concern.
	Storage: PSE believes it is more appropriate to allocate balancing costs based on annual weather normalized sales as balancing activities take place year round. PSE recommends updating the methodology to "Costs classified as balancing are allocated to all customers based on annual weather normalized sales."	Staff believes that the commission should decline to incorporate all sales in the allocation of storage costs. Winter sales are the primary driver of injection needs and the primary beneficiary of price arbitrage allowed by storage.
	Customer Service/Billing: Allocation methodology specifies "All costs assigned by weighted customer counts." Under the proposed rule it is unclear if actual customer counts could be used, which is the current practice of PSE. If weighted customer counts are required it would be helpful for the commission to define the methodology for calculating the weighting factors. PSE recommends further clarification for this allocation method.	The specific methodology for developing weights for customer counts is not identified since it is based on activities such as meter reading, billing, and collections which may differ amongst the utilities.
	Administrative & General and General Plant: PSE recommends the remainder of administrative and general and general plant costs also be allocated on standardized methods. Quite often disagreements continue to arise on cost allocation methods that have an immaterial impact on the cost of service study results. PSE is indifferent on the methods used to allocate the remainder of administrative & general and general plant costs.	Staff believes that the commission should decline to direct utilities to apply a specific method to administrative and general or specific factors for intangible plant because there can be significant variations amongst the structure companies use to manage their operations, especially for IT-related projects.
	Intangible Plant: Allocation Method: PSE seeks clarification on which appropriate factors to use to allocate intangible plant. Quite often disagreements continue to arise on cost allocation methods that have an immaterial impact on the cost of service study results. PSE is indifferent on the methods used to allocate intangible plant.	Staff believes that the commission should decline to direct utilities to apply a specific method to administrative and general or specific factors for intangible plant because there can be significant variations amongst the structure companies use to manage their operations, especially for IT-related projects.
Comments affecting WAC 480-85-070 Exemptions		
Subsection (1) A petition for exemption from any part of this chapter pursuant to WAC 480-07-110 must include…		
Stakeholder	**Summary of Comments**	**Staff Response**

Public counsel	To require parties to seek an exemption before they may present alternatives improperly limits the evidence that the commission has available in the record. Indeed, by requiring parties to seek an exemption, there is little room for any party to offer alternative studies or disagreement with the prescribed methodology.	Staff respectfully disagrees. The rule does not improperly limit what may be included in the record for the commission to consider as alternative evidence. Parties may present an alternative cost of service study and request an exemption for it as long as the party also files a cost of service study that complies with these rules. These rules do not prevent a party from petitioning for exemption during the course of a general rate case.
	The process required under the proposed rule is unclear. Staff's response to stakeholders in the summary of comments indicates that parties would be asked to seek exemptions outside of rate cases. It is difficult to envision when outside of a rate case filing that a party, other than a utility, might seek an exemption regarding cost of service studies.	Staff respectfully disagrees. The rule does not improperly limit what may be included in the record for the commission to consider as alternative evidence. Parties may present an alternative cost of service study and request an exemption for it as long as the party also files a cost of service study that complies with these rules. These rules do not prevent a party from petitioning for exemption during the course of a general rate case.
	It is reasonable for the commission to require parties appearing before it to present cost of service studies in a preferred methodology, and public counsel supports the efforts to streamline cost of service study presentations. It is unreasonable, however, to refuse parties the ability to present the best evidence they see fit for a particular case if they have met the commission's requirements. The commission can weigh the evidence and accord it the appropriate weight, given each utility's unique circumstances. Proposed WAC 480-85-070 is unnecessary.	The language in this section does not present too high a bar for stakeholders or companies to offer competing studies if they have a compelling reason to do so. Further, parties are still free to present arguments about the application of cost of service studies to individual customer classes (rate spread) and the final design of rates (rate design), which is consistent with public counsel's description of there being "no single or absolutely correct answer," as the commission does not apply a cost of service study through pure arithmetic, but also takes into consideration many other factors in rate spread and rate design.
Subsection (2) Under WAC 480-07-500(4), the commission will reject or require revision of any filing presenting a cost of service study that does not fully comply with this chapter unless a commission order has granted an exemption from this chapter.		
Stakeholder	**Summary of Comments**	**Staff Response**
PSE	This subsection appears to be duplicative with WAC 480-07-500(4), which already gives the commission authority to reject or revise any filing to initiate a general rate proceeding that is not in conformance with the rules. Additionally, PSE is unclear on the sequence to obtain an exemption. Would utilities be required to file a motion for exemption prior to filing of the COS study, or do utilities submit a COS study and request exemption at the time of filing? PSE recommends deleting this subsection as it is duplicative and causes confusion regarding the process in which a petition for exemption may be filed.	Staff believes that the commission should decline to remove this section because it provides clear guidance to utilities and stakeholders about what information will be necessary for the commission to make a determination under WAC 480-07-110 and the conditions under which a filing would not comply with the proposed rule.

AMENDATORY SECTION (Amending WSR 18-18-041, filed 8/29/18, effective 9/29/18)

WAC 480-07-510 General rate proceeding filings—Electric, natural gas, pipeline, and Class A telecommunications companies. General rate proceeding filings by electric, natural gas, pipeline, and Class A telecommunications companies as defined in WAC 480-120-034 must include the information described in this section. The company and all parties to an adjudication in a general rate proceeding must file all required documents in electronic form consistent with the requirements in WAC 480-07-140 and by the next business day must file five paper copies of all testimony and exhibits unless the commission establishes a different number. If an exhibit is a database, spreadsheet, or model, the paper copy of that exhibit may simply reference or describe its contents if printing the entirety of the database, spreadsheet, or model would result in a document exceeding five pages and would render the data, spreadsheet cells, or model unusable. The party, however, must submit a complete electronic version of the database, spreadsheet, or model, with all information, formulae, and functionality intact, as part of the party's electronic filing.

(1) **Testimony and exhibits.** The company's initial filing and any supplemental filings the commission authorizes must include all testimony and exhibits the company intends to present as its direct case. The company must serve a copy of the initial filing on the public counsel unit of the Washington state attorney general's office at the time the company makes the filing with the commission if the proceeding is the type in which public counsel generally appears or has appeared in the past. The filing must include a results-of-operations statement showing test year actual results and any restating and pro forma adjustments in columnar format that support the company's general rate request. The company must identify each restating and pro forma adjustment and the effect of that adjustment on the company's operations and revenue requirement. The testimony must include a written description of each proposed restating and pro forma adjust-

ment describing the reason, theory, and calculation of the adjustment.

(2) **Tariff sheets.** The company's initial filing must include the company's proposed new or revised tariff sheets in legislative format (i.e., with strike-through to indicate the material to be deleted or replaced and underlining to indicate the material to be inserted) consistent with the requirements in WAC 480-80-105, as well as copies of any tariff sheets that are referenced in the new or amended tariff sheets.

(3) **Detailed support for proposals.**

(a) *General*. The company must include in its initial testimony and exhibits, including those addressing accounting adjustments, sufficient detail, calculations, information, and descriptions necessary to meet its burden of proof. Any party responding to the company's proposal also must include in that party's testimony and exhibits sufficient detail, calculations, information, and descriptions necessary to support its filed case.

(b) *Capital structure and rate of return*. The company must include in testimony and exhibits a detailed description of the development of any capital structure and rate of return proposals. Any other party that files testimony or exhibits that propose revisions to the company's current capital structure or authorized rate of return also must provide similar detailed information in testimony and exhibits supporting its proposal.

(c) *Restating and pro forma adjustments*. Each party that proposes restating or pro forma adjustments must include in its testimony and exhibits a detailed portrayal of the restating and pro forma adjustments the party uses to support its proposal or position. That portrayal must specify all relevant assumptions and include specific references to charts of accounts, financial reports, studies, and all similar records on which the party relies. Testimony and exhibits must include support for, and calculations showing, the derivation of each input number used in the detailed portrayal, as well as the derivation of all interstate and multiservice allocation factors.

(i) Restating adjustments adjust the booked operating results for any defects or infirmities in actual recorded results of operations that can distort test period earnings. Restating adjustments are also used to adjust from an as-recorded basis to a basis that the commission accepts for determining rates. Restating adjustments must be calculated based on the unadjusted test year operating results, not on another party's adjustments. The commission may refuse to consider any adjustment that is not calculated consistent with this requirement. Nonexclusive examples of restating adjustments are adjustments that:

(A) Remove prior period amounts;

(B) Eliminate below-the-line items that were recorded as operating expenses in error;

(C) Adjust from book estimates to actual amounts;

(D) Annualize ongoing costs that the company began to incur part way through the test year;

(E) Normalize weather or hydro conditions; or

(F) Eliminate or normalize extraordinary items recorded during the test period.

(ii) Pro forma adjustments give effect for the test period to all known and measurable changes that are not offset by other factors. The company and any other party filing testimony and exhibits proposing pro forma adjustments must identify dollar values and underlying reasons for each proposed pro forma adjustment. Pro forma adjustments must be calculated based on the restated operating results. Pro forma fixed and variable power costs, net of power sales, may be calculated directly based either on test year normalized demand and energy load, or on the future rate year demand and energy load factored back to test year loads.

(iii) If a party proposes to calculate an adjustment in a manner different than the method the commission most recently accepted or authorized for the company, the party must also include in testimony and exhibits the rationale for, and documents that demonstrate, how that adjustment would be calculated under the methodology previously accepted by the commission and must explain the reason for the proposed change. Commission approval of a settlement does not constitute commission acceptance of any underlying methodology unless the commission so states in the order approving the settlement.

(d) *Revenue sources*. The company must include in testimony and exhibits a detailed portrayal of revenue from regulated sources, by source, during the test year and the changes that would result in those revenues if the commission approves the company's request, including an explanation of how the resulting changes were derived.

(e) *Achievement of rate of return*. The company must demonstrate in testimony and exhibits why the company has not achieved its authorized rate of return and what actions the company has taken prior to and during the test year to improve its earnings in addition to its request for increased rates. If the company has not taken any such actions, the company must explain why it has not.

(f) *Rate base and results of operations*. The company's testimony and exhibits must include a representation of the company's actual rate base and results of operations during the test period, calculated in the same manner the commission used to calculate the revenue requirement in the final order in the company's most recent general rate proceeding.

(g) *Affiliate and subsidiary transactions*. The company's testimony and exhibits must supplement, as necessary, the annual affiliate and subsidiary transaction reports required in rules governing reporting for the applicable industry to include all such transactions during the test period. The company must identify all affiliate and subsidiary transactions that materially affect the proposed rates. The company must support the allocation method the company used to distribute common costs between regulated and nonregulated affiliated entities and the dollar amount of those costs.

(h) *Electronic documents and confidentiality*. Electronic files must be fully functional and include all formulas and linked spreadsheet files. Electronic files that support exhibits must use logical file paths, as necessary, by witness and must use identifying file names consistent with the naming requirements in WAC 480-07-140. A party may file a document with locked, hidden, or password protected cells only if such restricted access is necessary to protect the information within the cells that is not subject to public disclosure. The party must identify each locked, hidden, or password protected cell and must designate such cells, as well as any other information the party contends is confidential under RCW

80.04.095 or otherwise protected from public disclosure, in compliance with the requirements in WAC 480-07-160 and any applicable protective order. The party must make such information accessible to all persons who have signed the protective order or are otherwise entitled to access the information including, but not necessarily limited to, commission staff and public counsel. Redacted versions of models or spreadsheets that contain information that is designated as confidential or highly confidential or otherwise protected from public disclosure must be in .pdf format (using Adobe Acrobat or comparable software) and must mask the information protected from public disclosure as required in WAC 480-07-160.

(i) *Referenced documents.* If a party's testimony or exhibits refer to a document including, but not limited to, a report, study, analysis, survey, article, or court or agency decision, the party's testimony and exhibits must include that document except as provided below:

(i) A party may include an official citation or internet Uniform Resource Locator (URL) to a commission order or to a court opinion or other state or federal agency decision, rather than the document itself, if that decision is reported in a generally accepted publication (e.g., Washington Reports Second (Wn.2d), Public Utility Reports (P.U.R.), etc.) or if the document is readily available on the web site of the agency that entered that decision;

(ii) A party may include only the relevant excerpts of a voluminous document if the party also provides a publicly accessible internet URL to the entire document or describes the omitted portions of the document and their content and makes those portions available to the other parties and the commission upon request; and

(iii) A party is not required to file or distribute materials subject to third-party copyright protection but must describe those materials and their content and make them available for inspection upon request by the parties and the commission.

(4) **Work papers.**

(a) *General*. Work papers are documents that support the technical aspects of a party's testimony and exhibits. Work papers may include, but are not limited to, calculations, data analysis and raw data. Work papers are not a part of a party's direct case. Within five business days after each party files and serves its testimony and exhibits, the party also must provide to all other parties the work papers on which each of its witnesses relied when preparing testimony and exhibits. All work papers must comply with the requirements of this subsection.

(b) *Organization*. Work papers must be plainly identified and well organized, with different documents or sections separated by or into tabs, and must include an index. All work papers must be cross-referenced and include a description of the cross-referencing methodology.

(c) Any work papers provided to other parties must comply with requirements governing electronic documents and confidentiality in subsection (3)(h) and referenced documents in subsection (3)(i) of this section.

(d) *Filing designated work papers with the commission*. If the commission determines that it needs information in addition to a party's testimony and exhibits, the commission may issue a bench request for designated portions of that party's work papers. The commission will receive into evidence the work papers a party provides in response to a bench request unless the commission rejects that response, either in response to an objection or on the commission's own motion, as provided in WAC 480-07-405 (7)(b). The commission will not rely on any other work papers as the basis for any finding of fact or conclusion of law in the proceeding unless the commission formally admits such work papers into the evidentiary record.

(5) **Summary document.**

(a) *Contents*. The company must include in its initial filing a document that summarizes the information in this subsection (5)(a) on an annualized basis, if applicable, and must itemize revenues from any temporary, interim, periodic, or other noncontinuing tariffs. The company must include in its rate change percentage and revenue change calculations any revenues from proposed general rate change tariffs that would supersede revenue from noncontinuing tariffs. The summary document must include:

(i) The date and amount of the last general rate change the commission authorized for the company and the revenue the company realized from that change during the test period based on the company's test period units of sale (e.g., kilowatt hours, therms, etc.);

(ii) Total revenues the company is realizing at its present rates and the total revenues the company would realize at the requested rates;

(iii) Requested revenue change in percentage, in total and by major customer class;

(iv) Requested revenue change in dollars, in total and by major customer class;

(v) The representative effect of the request in dollars for the average monthly use per customer, by customer class or other similar meaningful representation, including, but not limited to, the effect of the proposed rate change in dollars per month on residential customers by usage categories;

(vi) Most current customer count, by major customer class;

(vii) Current authorized overall rate of return and authorized rate of return on common equity;

(viii) Actual rate of return and actual rate of return on common equity for the test period;

(ix) Requested overall rate of return and requested rate of return on common equity, and the method or methods used to calculate the requested rates of return;

(x) Requested capital structure;

(xi) Requested net operating income;

(xii) Requested rate base and method of calculation, or equivalent; and

(xiii) Revenue effect of any requested attrition allowance.

(b) *Required service*.

(i) Persons to receive service. The company must serve the summary document on the persons designated below on the same date it files the summary document with the commission:

(A) The public counsel unit of the Washington state attorney general's office;

(B) All intervenors on the commission's master service list for the company's most recent general rate proceeding;

(C) All intervenors on the master service list for any other rate proceeding involving the company during the five years prior to the company's filing, if the company's rate change request may affect the rates established or considered in that prior proceeding; and

(D) All persons who have informed the company in writing that they wish to be provided with the summary document required under this section.

(ii) Cover letter. The company must enclose a cover letter with the summary document stating that the company's prefiled testimony and exhibits, and the accompanying work papers, are available from the company on request, subject to any restrictions on information that is protected from public disclosure, if the company is not serving them along with the summary document.

(iii) Limitation. This service requirement does not create a right to service or notice of future filings in the proceeding to the persons named to receive the summary. Any person other than commission staff and public counsel who wishes to be served documents subsequently filed in the general rate proceeding must petition to intervene in that proceeding.

(6) **Cost of service studies.** The ((~~company's~~)) initial filing must((~~: (a) Include any cost studies the company performed or relied on to prepare its proposals; (b) identify all cost studies conducted in the last five years for any of the company's services; and (c) describe the methodology the company used in all such cost studies. If the cost studies are in the form of a model, the company must provide a copy of, or reasonable access to, the model that will enable the commission to verify and modify the model's inputs and assumptions~~)) include a cost of service study that complies with chapter 480-85 WAC.

(7) **Additional documents.** The company's initial filing must include the following documents or an internet URL for each of these documents:

(a) The company's most recent annual report to shareholders, if any, and any subsequent quarterly reports to shareholders;

(b) The company's most recent FERC Form 1 and FERC Form 2 for electric and natural gas companies; and

(c) The company's Form 10K's, Form 10Q's, any prospectuses for any issuances of securities, and quarterly reports to stockholders, if any, for the most recent two years prior to the rate change request.

Chapter 480-85 WAC

ELECTRIC AND NATURAL GAS COST OF SERVICE

NEW SECTION

WAC 480-85-010 Purpose. (1) The purpose of these rules is to establish minimum filing requirements for any cost of service study filed with the commission. These rules are designed to streamline, improve, and promote efficiency in analyzing rate cases, clarity of presentation, and ease of understanding. The minimum filing requirements will allow for comparisons of cost of service studies.

(2) The cost of service study is one factor among many the commission considers when determining rate spread and rate design. The commission may also consider, as appropriate, such factors as fairness, perceptions of equity, economic conditions in the service territory, gradualism, and rate stability.

NEW SECTION

WAC 480-85-020 Applicability. The rules in this chapter apply to any person or party who files a cost of service study in any proceeding before the commission.

NEW SECTION

WAC 480-85-030 Definitions. (1) "Allocation factor" means a mathematical expression of the specific cost relationship among revenue requirement and customer classes.

(2) "Common function" means costs that can be functionalized to both electric and natural gas operations.

(3) "Cost of service study" means a study that identifies and calculates, using regulatory accounting rules and principles, the extent to which customers in various customer classes cause costs to a utility. This study correlates a utility's costs and revenues with the service provided to customers in each customer class.

(4) "Electric distribution system peak" means the maximum load of the Washington portion of a utility's distribution system within an identified time frame.

(5) "Load study" means a statistical analysis of load data collected from sampled customers to estimate the load profiles of customer classes over a minimum twelve-month period. Load profile estimates of customer classes shall be hourly (or subhourly) for electric, and daily for natural gas. A load forecast or load projection model is not a substitute for a load study.

(6) "Parity ratio" means a customer class's revenue-to-cost ratio divided by the system's revenue-to-cost ratio. This ratio shall only be presented to the commission as either a percentage or a decimal.

(7) "Revenue-to-cost ratio" means revenue at current rates divided by the revenue requirement. This ratio shall only be presented to the commission as either a percentage or a decimal.

(8) "Special contract" means a negotiated service agreement between a utility and a customer approved pursuant to WAC 480-80-143.

NEW SECTION

WAC 480-85-040 Minimum filing requirements. (1) All cost of service study results must be filed in the following forms, available from the commission: Electric cost of service template; and, gas cost of service template. In addition, the following must be provided contemporaneously with all cost of service studies:

(a) Supporting testimony. All cost of service studies must be filed with supporting testimony and exhibits. If supporting testimony or exhibits reference, discuss, or specifically rely on data, models, calculations, or associated information found only in the supporting work papers, the supporting testimony or exhibit must cite to the work papers.

(b) Supporting work papers. In addition to complying with WAC 480-07-140 (6)(a)(ii), all supporting models, cal-

culations, data, and associated information must be provided to the parties in a manner that allows for the verification and modification of all of the model's inputs and assumptions. This includes:

(i) All models must be fully functional, which requires, at a minimum, that cells are linked where possible and all formulas are calculable. Wherever practical, all associated calculations necessary to support the results of the study must be consolidated in the same electronic workbook file.

(ii) Any macros in a model must be explained in a narrative. The narrative must also identify where each macro is found in the model.

(iii) Each electronic cost of service workbook must have an index identifying links to any external spreadsheet.

(2) Companies that provide electric and natural gas service must file a cost of service study for their electric and natural gas operations. If a company providing electric and natural gas service files a general rate case for only one of its services, the company must apportion the common costs shared by both services in lieu of filing a cost of service study for the service not included in the general rate case.

NEW SECTION

WAC 480-85-050 Cost of service study inputs. (1) The rate schedule usage data for any cost of service study must come from the best available source: Advanced metering technology, including advanced metering infrastructure (AMI) and advanced meter reading (AMR); or, a load study.

(a) For utilities with AMI, the use of data from a load study must be explicitly justified.

(b) For utilities with AMR, data from AMR may be used if granularity of the data meets or exceeds hourly for electric and daily for natural gas. For utilities with AMR with the data granularity required by this subsection, the use of data from a load study must be explicitly justified.

(c) For utilities with other advanced metering technology, data from that metering technology may be used if granularity of the data meets or exceeds hourly for electric and daily for natural gas. For utilities with other advanced metering technology with the data granularity required by this subsection, the use of data from a load study must be explicitly justified.

(d) For utilities that do not have advanced metering technology described in subsection (1), (2), or (3) of this section, a load study must be used. Data from special contracts may be used in a load study.

(e) Street lighting schedules may be estimated and, if so, the estimation method must be explicitly presented in testimony and exhibits.

(2) Rate schedule usage data for any cost of service study must not be older than five years.

NEW SECTION

WAC 480-85-060 Cost of service methodology. (1) A cost of service study filed with the commission must be calculated using an embedded cost method.

(a) Electric studies shall use the FERC accounts outlined in Table 1 in subsection (3) of this section to functionalize the cost of service. Costs shall be directly functionalized where information is available. Functionalized costs will be classified and allocated by the methods outlined in Table 2 in subsection (3) of this section.

(b) Natural gas studies shall use the FERC accounts outlined in Table 3 in subsection (3) of this section to functionalize the cost of service. Costs shall be directly functionalized where information is available. Functionalized costs will be classified and allocated by the methods outlined in Table 4 in subsection (3) of this section.

(c) FERC accounts not included in Table 1 or Table 3 in subsection (3) of this section but identified in a cost of service study must be accompanied by a rationale for the functional method chosen in the supporting testimony.

(d) If an allocation method in Table 2 or Table 4 in subsection (3) of this section requires direct assignment, any similar remaining costs in the account may not be allocated to the classes included in the direct assignment; except in circumstances where that class derives a direct benefit from the nondirect assigned costs. If a particular account contains several cost items, of which only certain items in the FERC account are directly assigned, the cost items that are not directly assigned will be allocated as appropriate.

(e) The abbreviations for the functionalized costs are:

"Comm" is an abbreviation meaning the common function;

"Cust" is an abbreviation meaning the customer function;

"Dist" is an abbreviation meaning the distribution function;

"Gen" is an abbreviation meaning the generation function, for electric;

"Prod" is an abbreviation meaning the production function, for natural gas;

"Stor" is an abbreviation meaning the storage function, for natural gas; and

"Tran" is an abbreviation meaning the transmission function.

(2) In addition to filing a cost of service study as required in subsection (1) of this section, a party may file a cost of service study based on a system-wide econometric study, a system-wide marginal cost study, or an embedded cost of service study with modifications to the methodologies outlined in Tables 1 through 4 in subsection (3) of this section provided that each modification is explained in narrative testimony and the party shows that each modification materially improves the cost of service study and is in the public interest.

(3) Tables 1 through 4 of this subsection outline the functionalization, classification, and allocation methods required by subsection (1) of this section.

Table 1
Electric Cost of Service Approved Functionalization Methodologies

Functionalization	FERC Account Numbers
Generation	151, 152, 310-317, 330-337, 340-348, 500-515, 535-545.1, 546-557
Transmission	350-359.1, 560-573

Functionalization	FERC Account Numbers
Distribution	252, 360-374, 580-598
Customer	235, 901-905, 907, 908* 909-910
Common	920-935, working capital allowance
Gen/Tran/Dist/Cust/Comm	301-303, 403, 403.1, 404-407
Gen/Tran/Dist/Comm	105, 107, 108, 111, 154, 165, 281, 282, 389-398
Allocate based on subaccount	182.3, 253, 254

*Expenses included in account 908 that are related to conservation must be functionalized as generation related.

Table 2
Electric Cost of Service Approved Classification and Allocation Methodologies

Functionalized Cost	Classification Method	Allocation Method
Generation	Renewable future peak credit with net power costs allocated on energy	Load net of renewable generation, using 12 coincident peaks. Net power costs are allocated using annual energy usage at the point of generation.
Transmission	Demand	12 coincident peaks.
Distribution Substation	Demand	Direct assignment to large customer classes based on load ratio share of substations they are fed from; for this allocator only, the utility may determine "large customer." All other classes use an average of the relative share of the summer distribution system coincident peak and the relative share of the winter distribution system coincident peak.
Distribution Line Transformers	Demand	Secondary customers directly assigned where practical. All remaining costs are allocated using a relative ratio of transformers at current installation costs. Allocation to the lighting class(es) may be based upon its proportion of noncoincident peak to the sum of noncoincident peaks for all secondary voltage customers.
Distribution Poles and Wires	Demand	Primary system customers are allocated using the same method as distribution substation, where practical. When not practical, allocate using 12 distribution system noncoincident peaks. Secondary system customers are allocated using 12 distribution system noncoincident peaks.
Service Lines	Customer	Average installed cost for new service lines multiplied by customer count relative to total installed cost.
Meters	Customer	Average installed cost for new metering multiplied by customer or meter count.
Customer Service/Billing	Customer	All costs assigned by weighted customer counts.
Administrative & General and General Plant	Depends on functionalization of account	Property insurance and property taxes based on allocated plant; pensions and employee insurance based on salary and wages; FERC fees based on energy; revenue-based fees allocated by class relative share of total revenue. The remainder of administrative & general and general plant costs shall be allocated as deemed appropriate. An explanation of the allocation method used must be included in testimony.
Intangible Plant	Depends on functionalization of account	Each type of intangible and amortization in a separate account, allocated using appropriate factors. A materiality threshold of 0.5% of intangible plant will be applied.

Table 3
Natural Gas Cost of Service Approved Functionalization Methodologies

Functionalization	FERC Account Numbers
Production	800-813
Storage	350-356, 352.1, 352.2, 352.3, 814-826, 830-837, 840-843, 842.1-842.3, 843.1-843.9
Transmission	365.1, 365.2, 366-371, 850-867, 870
Distribution	374-387, 871-881, 885-894
Customer	901-905, 907, 908*, 909-910
Common	920-935, working capital
Prod/Tran/Dist/Stor/Comm	101.1, 104-108, 111, 114, 115, 117.1-117.4, 165, 182.3, 186, 190, 228.1-228.4, 229, 235, 252, 253, 255, 281-283, 301-303, 389-398, 403
Allocate based on subaccount	182.3, 254

*Expenses included in account 908 that are related to conservation must be functionalized as production related.

Table 4
Natural Gas Cost of Service Approved Classification and Allocation Methodologies

Functionalized Cost	Classification Method	Allocation Method
Distribution Mains	Demand	Direct assignment of distribution mains to a single customer class where practical. All other costs assigned based on design day (peak) and annual throughput (average) based on system load factor.
Transmission Main	Follows distribution mains	Follows distribution mains.
Distribution Assets	Follows distribution mains	Follows distribution mains.
Storage	Determined on a case-by-case basis	Costs classified as balancing are allocated to all customers based on winter sales. All remaining costs are allocated to sales customers with a ratio based on average winter sales that exceed average summer sales.
Services	Customer	Allocated to customer class based on the class average service installation cost. Large customers are directly assigned based on a special study; for only this allocator, it is up to the utility to determine "large customer."
Meters	Customer	Average installed cost for new metering multiplied by customer or meter count.
Customer Service/Billing	Customer	All costs assigned by weighted customer counts.
Administrative & General and General Plant	Depends on functionalization of account	Property insurance and property taxes based on allocated plant; pensions and employee insurance based on salary and wages; FERC fees based on energy; revenue-based fees allocated by class relative share of total revenue. The remainder of administrative & general and general plant costs shall be allocated as deemed appropriate. An explanation of the allocation method used must be included in testimony.
Intangible Plant	Depends on functionalization of account	Each type of intangible and amortization in a separate account, allocated using appropriate factors. A materiality threshold of 0.5% of intangible plant will be applied.

NEW SECTION

WAC 480-85-070 Exemptions from rules in chapter 480-85 WAC. The commission may grant an exemption from the provisions of any rule in this chapter in the same manner and consistent with the standards and according to the procedures set forth in WAC 480-07-110 (exceptions from and modifications to the rules in this chapter; special rules).

WSR 20-16-006
PERMANENT RULES
DEPARTMENT OF RETIREMENT SYSTEMS

[Filed July 22, 2020, 4:12 p.m., effective August 22, 2020]

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

Purpose: To waive and suspend limits on postretirement employment during a period of emergency proclaimed by the governor under RCW 43.06.010(12).

Citation of Rules Affected by this Order: WAC 415-02-160 Will postretirement employment performed during a period of emergency affect my retirement benefit?

Statutory Authority for Adoption: RCW 41.50.050.

Adopted under notice filed as WSR 20-13-096 on June 17, 2020.

Date Adopted: July 22, 2020.

Tracy Guerin
Director

NEW SECTION

WAC 415-02-160 Will postretirement employment performed during a period of emergency affect my retirement benefit? During a period of emergency proclaimed by the governor under RCW 43.06.010(12) regarding the COVID-19 pandemic, and for which the governor has waived or suspended applicable statutory limitations, public service employment performed by a retiree shall not cause a suspension or reduction of retirement benefits.

For the purpose of this section, a "period of emergency" includes only the following: COVID-19 pandemic, for the period covered by the governor's proclamation.

WSR 20-16-010
PERMANENT RULES
DEPARTMENT OF AGRICULTURE

[Filed July 23, 2020, 6:34 a.m., effective August 23, 2020]

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

Purpose: This rule-making order amends chapter 16-390 WAC, Fruit and vegetable inspection fees and other charges by: (1) Increasing the apple maggot survey fee to $0.020 per CWT (hundredweight); (2) establishing a mechanism to trigger a secondary future fee increase to $0.025 per CWT; and [(3)] adding a definition for 'Minimum Operating Fund Balance (MOFB).'

Citation of Rules Affected by this Order: Amending WAC 16-390-005 and 16-390-230.

Statutory Authority for Adoption: RCW 17.24.101 and 17.24.131.

Adopted under notice filed as WSR 20-11-069 on May 20, 2020.

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 2, 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: July 22, 2020.

Derek I. Sandison
Director

AMENDATORY SECTION (Amending WSR 14-24-086, filed 12/1/14, effective 1/1/15)

WAC 16-390-005 Definitions. "Certificate" means an official document issued by the director which reports certification results.

"Certificate of compliance" means a shipping document issued by the fruit and vegetable industry attesting that the identified fruits or vegetables are known to be in full compliance with provisions of chapter 15.17 RCW. The member of the fruit and vegetable industry issuing the certificate of compliance has the sole responsibility of fairly and accurately representing the quality and quantity of fruits and vegetables listed on the certificate of compliance.

"Certification" means the complete service performed by the director, from inspection through the issuance of any applicable documentation of the results of the inspection.

"Customer assisted inspection program (CAIP)" means a quality or condition inspection performed by industry using the United States Department of Agriculture (USDA) standards with verification and oversight by the director.

"CWT" means a hundredweight, a unit of measure equaling one hundred pounds.

"Director" means the director of the department of agriculture or the director's designated representative. As used in this chapter, WSDA refers to the director unless the context states otherwise.

"Grade and condition certificate" means an official note sheet issued by the director confirming the results of an inspection.

"Hourly fee" means the fee charged for services based on the hours documented by each WSDA inspector providing the service. Hourly fees are charged based on increments of

fifteen minutes, with time rounded up or down to the next fifteen minute interval as follows: Eight minutes into a quarter hour is rounded up to the full quarter hour. Less than eight minutes into a quarter hour is rounded down and not billed.

"Inspection" means the inspection by the director of any fruits or vegetables for the purpose of certification at any time prior to, during, or subsequent to harvest.

"Inspection service notification" means customer notification to the director of any request for inspection services.

"Lot" means, unless otherwise stated in this chapter, a distinct unit of fruits or vegetables.

"Minimum operating fund balance" or **"MOFB"** means six months of projected apple maggot survey program operating expenses. The factors that the department considers when setting the MOFB under WAC 16-390-230 include the projected program staff salary and benefits; costs of the program's goods and services, including transportation; costs associated with the department's administrative support of the program; and any additional costs associated with the program. In addition to expected future costs, the department may consider previously incurred operating expenses to estimate projected operating expenses.

"Regular business hours" means the hours between 8:00 a.m. and 5:00 p.m. Pacific time Monday through Friday except state holidays.

"Shipping permit" means a shipping document issued by the director attesting that the fruits or vegetables are known to be in compliance with the provisions of chapter 15.17 RCW and this chapter.

AMENDATORY SECTION (Amending WSR 14-24-086, filed 12/1/14, effective 1/1/15)

WAC 16-390-230 Apple maggot survey fees. The fee for the apple maggot survey program on all apples grown or packed in Washington state and introduced into commerce for sale or shipment as fresh apples is ((~~$.015 per CWT~~)) $.020 per CWT, unless and until the program fund balance falls below the minimum operating fund balance. This fee is assessed by the director on all certificates of compliance and all shipping permits.

(1) The department shall establish the minimum operating fund balance amount on the first business day of February each year unless the fee has been previously set at $.025 per CWT.

(2) At the time the minimum operating fund balance amount is established, if the program fund balance is below the new minimum operating fund balance, the fee rate shall be set at $.025 per CWT beginning July 1st of that year.

(3) The department shall post notice of the minimum operating fund balance on the department's website by February 10th of each year unless the fee has been previously set at $.025 per CWT.

(4) The department shall post notice of the apple maggot survey fee by February 10th of each year.

WSR 20-16-011
PERMANENT RULES
DEPARTMENT OF AGRICULTURE

[Filed July 23, 2020, 6:35 a.m., effective August 23, 2020]

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

Purpose: This rule-making order amends chapter 16-06 WAC, Public records, by:

1. Repealing public record exemptions already specified in chapter 42.56 RCW, Public Records Act;

2. Repealing the industrial hemp research program exemption;

3. Providing details on how the public can submit record requests utilizing the online public disclosure web portal;

4. Adding language specifying that inspection or copying of records may only be done during customary business hours;

5. Adding language requiring the agency to maintain a list of commonly used exemptions on the public website;

6. Modifying the language to increase clarity and readability; and

7. Removing obsolete language.

Citation of Rules Affected by this Order: Amending WAC 16-06-160, 16-06-190, and 16-06-210.

Statutory Authority for Adoption: RCW 42.56.040.

Adopted under notice filed as WSR 20-11-073 on May 20, 2020.

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 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 3, Repealed 0.

Date Adopted: July 22, 2020.

Derek I. Sandison
Director

AMENDATORY SECTION (Amending WSR 14-19-056, filed 9/12/14, effective 10/13/14)

WAC 16-06-160 Description of department, address and telephone number of Olympia administrative offices. Headquartered in Olympia and located in the Natural Resources Building, 1111 Washington Street S.E., P.O. Box 42560, Olympia, Washington 98504-2560, the department employs personnel in every county in Washington. The department serves the people of Washington state by supporting the agricultural community and promoting consumer and environmental protection since 1913. The information tele-

phone number is 360-902-1800. The department is organized into seven functional areas:

(1) Director's office;

(2) Administrative services;

(3) Animal services division;

(4) Commodity inspection division;

(5) Food safety and consumer services division;

(6) Pesticide management division; and

(7) Plant protection division.

The department maintains service locations or major field offices around the state. The administrative offices located in Olympia can assist persons in locating office locations around the state. The department's organization chart is available upon request from the Public Records Officer, Washington State Department of Agriculture, P.O. Box 42560, Olympia, Washington 98504-2560, phone 360-902-1935, fax 360-902-2092 ((~~and also on the agency website. The public is encouraged to view the organization chart on the website~~)).

AMENDATORY SECTION (Amending WSR 09-03-032, filed 1/12/09, effective 2/12/09)

WAC 16-06-190 Public records requests. (1) ((~~A person wishing to inspect or copy the department's public records may make the request in writing on the department's public records request form or in writing by first class mail, email, or fax. Requests for public records may be initiated at any department office during customary business hours, Monday through Friday, excluding legal holidays.~~)) Persons seeking public records are encouraged to use the online public records center portal on the department's website at https://agr.wa.gov/contact-us/public-disclosure.

(2) Alternatively, a request may be submitted to the public records officer in writing using the department's public records request form or other written format using the following methods:

(a) By mail at: Washington State Department of Agriculture, Attn: Public Records Officer, P.O. Box 42560, Olympia, Washington 98504-2560;

(b) By email at publicdisclosure@agr.wa.gov; or

(c) By fax to 360-902-2092.

(3) Requests must include the following information:

(a) The name, address and telephone number or other contact information of the person requesting the records;

(b) The date on which the request is made; and

(c) Sufficient information to readily identify records being requested.

(((~~(2)(a) The request should be submitted to the public records officer at: Washington State Department of Agriculture, P.O. Box 42560, Olympia, Washington 98504-2560.~~

~~(b) The request may also be submitted by fax to 360-902-2092 or by email at: publicdisclosure@agr.wa.gov.~~

~~(3)~~)) (4) If a requestor cannot submit a request for public records in writing and desires to make an oral request either in person or by telephone, the public records officer or designee receiving the request will summarize the request in writing and then verify in writing with the requestor that the summary correctly memorializes the request.

(5) A person wishing to inspect or copy the department's public records may do so during customary business hours, Monday through Friday, excluding legal holidays.

AMENDATORY SECTION (Amending WSR 17-20-102, filed 10/4/17, effective 11/4/17)

WAC 16-06-210 Exemptions. (1) The Public Records Act ((~~provides that a number of types of information or records are exempt from public inspection and copying. In addition, records~~)) exempts a number of types of records from public disclosure (see chapter 42.56 RCW).

(2) Records are also exempt from disclosure if any other statute exempts or prohibits disclosure. Requestors should be aware of the following exemptions ((~~to public disclosure specific to department records~~)) outside of the Public Records Act, which restrict the availability of some records held by the department. This list is not exhaustive and other exemptions may apply:

(((~~(1) Personal information in any files maintained for employees, appointees, or elected officials of any public agency to the extent that disclosure would violate their right to privacy (reference RCW 42.56.230(3)).~~

~~(2) Investigative records (reference RCW 42.56.240).~~

~~(3) Test questions, scoring keys, and other examination data used to administer a license (reference RCW 42.56.250 (1)).~~

~~(4) Records that are relevant to a controversy to which an agency is a party but which records would not be available to another party under the rules of pretrial discovery for causes pending in the superior courts (reference RCW 42.56.290).~~

~~(5) Lists of individuals requested for commercial purposes (reference RCW 42.56.070(9)).~~

~~(6) Records related to the entry of prohibited agricultural products imported into Washington state or that had Washington state as a final destination received from the United States Department of Homeland Security or the United States Department of Agriculture that are not disclosable by the federal agency under federal law including 5 U.S.C. Sec. 552 (reference RCW 42.56.380(12)).~~

~~(7) Credit card numbers, debit card numbers, electronic check numbers, card expiration dates, or bank or other financial account numbers, except when disclosure is expressly required or governed by other law (reference RCW 42.56.230 (5)).~~

~~(8) Applications for public employment, including the names of applicants, resumes, and other related materials submitted with respect to the applicant (reference RCW 42.56.250(2)).~~

~~(9) Residential addresses, residential telephone numbers, personal wireless telephone numbers, personal electronic mail addresses, Social Security numbers, driver's license numbers, and emergency contact information of employees or volunteers of a public agency, and the names, dates of birth, residential addresses, residential telephone numbers, personal wireless telephone numbers, personal electronic mail addresses, Social Security numbers, and emergency contact information of dependents of employees or volunteers of a public agency that are held by any agency in personnel records, public employment related records, or volun-~~

teer rosters, or are included in any mailing list of employees or volunteers of any public agency (reference RCW 42.56.250(3)).

(10) Information provided for the semi-annual report for fertilizers, minerals and limes that would reveal the business operation of the person making the report (reference RCW 15.54.362(5) and 42.56.380(2)).

(11))) (a) The semiannual report required in the Commercial Feed Act ((is not a public record, and any information given in such report which would reveal the business operation of the person making the report is exempt from disclosure, and information obtained by the department from other governmental agencies or other sources that is used to verify information received in the report is exempt from public disclosure)) (reference RCW 15.53.9018).

(((12))) (b) The department has the authority to publish reports of official seed inspections, seed certifications, laboratory statistics, verified violations of this chapter, and other seed branch activities which do not reveal confidential information regarding individual company operations or production (reference RCW 15.49.370(8)).

(((13) Business related information obtained under the Organic Food Products Act concerning an entity certified under that act or an applicant for certification under RCW 15.86.110, and records whose disclosure is prohibited by the federal Organic Certification Act, 7 U.S.C. Sec. 6515(g) and the rules adopted under that act (reference RCW 42.56.380(1)).

(14) Consignment information contained on phytosanitary certificates issued by the department under chapters 15.13, 15.17, and 15.49 RCW or federal phytosanitary certificates issued under 7 C.F.R. 353 through cooperative agreements with the animal and plant health inspection service, United States Department of Agriculture, or on applications for phytosanitary certification required by the department (reference RCW 42.56.380(4)).

(15) Financial and commercial information and records supplied by businesses or individuals during application for loans or program services provided by the former chapter 15.110 RCW or chapter 43.325 RCW (the energy freedom loan program) (reference RCW 42.56.270(4)).

(16) Information obtained under RCW 15.19.080 regarding the purchases, sales, or production of an individual American ginseng grower or dealer (reference RCW 42.56.380(6)).

(17))) (c) Financial statement information required ((to determine whether or not an applicant for a license to operate a warehouse under chapter 22.09 RCW, agriculture commodities, meets minimum net worth requirements (reference RCW 22.09.040(9)).

(18) All financial statement information to determine whether or not an applicant for a license to be a grain dealer under chapter 22.09 RCW meets the minimum net worth requirements (reference RCW 22.09.045(7)).

(19) Information submitted by an individual or business to the department of agriculture under the requirements of chapters 16.36, 16.57, and 43.23 RCW for the purpose of herd inventory management for animal disease traceability, is exempt from disclosure. This information includes animal ownership, numbers of animals, locations, contact information, movements of livestock, financial information, the purchase and sale of livestock, account numbers or unique identifiers issued by government to private entities, and information related to livestock disease or injury that would identify an animal, a person or location. Disclosure to local, state, and federal officials is not public disclosure. This exemption does not affect the disclosure of information used in reportable animal health investigations under chapter 16.36 RCW once they are complete (reference RCW 42.56.380(9)).

(20) Results of testing for animal diseases from samples submitted by or at the direction of the animal owner or the owner's designee and that can be identified to a particular business or individual is exempt from disclosure (reference RCW 42.56.380(10)).

(21) Information that can be identified to a particular business and that is collected under chapter 15.17 RCW, standards of grades and packs, and specifically RCW 15.17.140(2) and 15.17.143 for certificates of compliance (reference RCW 42.56.380(7)).

(22) Financial statement information provided under RCW 16.65.030 (1)(d), public livestock markets, is confidential information and not subject to public disclosure (reference RCW 16.65.030 (1)(d) and 42.56.380(8)).

(23))) under RCW 22.09.040(9) or 22.09.045(7).

(d) Privileged or confidential information or data that contains trade secrets, commercial, or financial information ((and is required and)) submitted under the Washington Pesticide Control Act (reference RCW 15.58.060 (1)(c) and 15.58.065).

(((24) Except for release of statistical information not descriptive of any readily identifiable person or persons, all financial and commercial information and records supplied by persons to the department with respect to export market development projects (reference RCW 43.23.270 and 42.56.270(3)).

(25))) (e) Information submitted by an applicant under chapter 17.24 RCW that is privileged or confidential because it contains trade secrets or commercial or financial information (reference RCW 17.24.061).

(((26) Production or sales records required to determine assessment levels and actual assessment payments to commodity boards and commissions formed under chapters 15.24, 15.26, 15.28, 15.44, 15.65, 15.66, 15.74, 15.88, 15.89, 15.100, and 16.67 RCW, or required by the department to administer these chapters or the department's programs (reference RCW 42.56.380(3)).

(27) Financial and commercial information and records supplied by persons:

(a) To the department for the purpose of conducting a referendum for the potential establishment of a commodity board or commission; or

(b) To the department or commodity boards or commissions formed under chapters 15.24, 15.28, 15.44, 15.65, 15.66, 15.74, 15.88, 15.89, 15.100, or 16.67 RCW, with respect to domestic or export marketing activities or individual producer's production information (reference RCW 42.56.380(5)).

(28) Farm plans developed by conservation districts, unless the farm plan is used for the application or issuance of a permit (reference RCW 42.56.270(17)).

~~(29)~~)) (f) Under RCW 42.56.610 and 90.64.190, information identifying the number of animals; volume of livestock nutrients generated; number of acres covered by the plan or used for land application of livestock nutrients; livestock nutrients transferred to other persons; and crop yields in plans, records, and reports obtained by state and local agencies from dairies, animal feeding operations, and concentrated animal feeding operations not required to apply for a National Pollutant Discharge Elimination System permit is disclosable in the following ranges:

((~~(a)~~)) (i) Number of animals: Beef cattle
1 to 19
20 to 159
160 to 299
300 to 999
1,000 to 5,999
6,000 to 10,999
11,000 to 15,999
16,000 to 20,999
21,000 to 25,999
26,000 to 31,199
31,200 to 37,439
37,440 to 44,999
45,000 and above

((~~(b)~~)) (ii) Number of animals: Mature dairy cattle
1 to 37
38 to 199
200 to 699
700 to 1,699
1,700 to 2,699
2,700 to 3,699
3,700 to 4,699
4,700 to 5,699
5,700 to 6,839
6,840 and above

((~~(c)~~)) (iii) Number of animals: Dairy heifers
1 to 49
50 to 149
150 to 299
300 to 999
1,000 to 1,999
2,000 to 2,999
3,000 to 3,999
4,000 and above

((~~(d)~~)) (iv) Number of animals: Swine (fifty-five pounds or greater)
1 to 19
20 to 159
160 to 399
400 to 749
750 to 2,499
2,500 to 4,249
4,250 to 5,999
6,000 to 7,749
7,750 and above

((~~(e)~~)) (v) Number of animals: Swine (less than fifty-five pounds)
1 to 99
100 to 499
500 to 1,099
1,100 to 1,999
2,000 to 2,999
3,000 to 9,999
10,000 to 16,999
17,000 to 23,999
24,000 to 30,999
31,000 and above

((~~(f)~~)) (vi) Number of animals: Layers (all ages)
1 to 199
200 to 999
1,000 to 10,999
11,000 to 24,999
25,000 to 81,999
82,000 to 138,999
139,000 to 195,999
196,000 to 252,999
253,000 to 309,999
310,000 to 371,999
372,000 to 446,399
446,400 to 535,679
535,680 to 642,815
642,816 to 771,379
771,380 to 925,655
925,656 to 1,110,787
1,110,788 to 1,332,945
1,332,946 and above

((~~(g)~~)) (vii) Number of animals: Broilers (all ages)
1 to 199
200 to 999
1,000 to 17,999
18,000 to 37,499
37,500 to 124,999
125,000 to 212,499
212,500 to 299,999
300,000 and above

((~~(h)~~)) (viii) Number of animals: Horses
1 to 19
20 to 79
80 to 149
150 to 499
500 to 849
850 to 1,199
1,200 to 1,549
1,550 and above

((~~(i)~~)) (ix) Livestock nutrients generated or exported by volume (ft^3/day)
1 to 74
75 to 134
135 to 299
300 to 449
450 to 749
750 to 1,499
1,500 to 2,499
2,500 to 4,999
5,000 to 8,499
8,500 to 11,999
12,000 to 15,999
16,000 and above

((~~(j)~~)) (x) Livestock nutrients generated or exported by weight (tons/year)

1 to 5,256
5,257 to 10,512
10,513 to 21,024
21,025 to 42,048
42,049 to 84,096
84,097 to 164,184
164,185 to 262,734
262,735 to 394,200
394,201 to 558,384
558,385 to 722,634
722,635 to 919,734
919,735 to 1,051,134
1,051,135 and above

(((~~(k)~~))) (xi) Number of acres covered by the plan or used for land application of livestock nutrients

0 to 25
26 to 65
66 to 120
121 to 300
301 to 550
551 to 900
901 to 1,300
1,301 to 1,800
1,801 to 2,500
2,501 to 3,200
3,201 to 4,000
4,001 to 6,000
6,001 to 9,000
9,001 to 11,500
11,501 to 14,000
14,001 and above

(((~~(l)~~))) (xii) Crop yields - tons/acre

0 to 1
1.1 to 2
2.1 to 3.5
3.6 to 5
5.1 to 7
7.1 to 9
9.1 to 12
12.1 to 14.5
14.6 to 17
17.1 to 19.5
19.6 to 22
22.1 to 26
26.1 and above

(((~~(30) Records of international livestock importation that can be identified to a particular animal, business, or individual received from the United States Department of Homeland Security or the United States Department of Agriculture that are not disclosable by the federal agency under federal law including 5 U.S.C. Sec. 552 (reference RCW 42.56.380(11)).~~

~~(31)~~))) (g) A person aggrieved by a violation of chapter 17.21 RCW or the rules adopted under that chapter is entitled, on request, to have his or her name protected from disclosure in any communication with persons outside the department and in any record published, released, or made available to persons outside the department except as provided in RCW 17.21.340 (1)(a)(ii).

(((~~(32) All records, data, and information filed in support of an industrial hemp research program license application (reference RCW 15.120.050(7)).~~

~~(33) Effective April 1, 2018,~~)) (h) Information about marijuana processors otherwise exempt from public inspection and copying under chapter 42.56 RCW is also exempt from public inspection and copying if submitted to or used by the department (reference RCW 69.07.200(4)).

(((~~(34)~~))) (i) Information about marijuana producers, marijuana processors, and marijuana retailers otherwise exempt from public inspection and copying under chapter 42.56 RCW is also exempt from public inspection and copying if submitted to or used by the department (reference RCW 15.125.050).

(3) A list of common record exemptions can be found on the department's website.

WSR 20-16-024
PERMANENT RULES
PUGET SOUND CLEAN AIR AGENCY

[Filed July 23, 2020, 4:23 p.m., effective September 1, 2020]

Effective Date of Rule: September 1, 2020.

Purpose: The revisions will incorporate the Washington department of ecology's (ecology) recently adopted updates to chapter 173-460 WAC into the Puget Sound Clean Air Agency (agency) regulations. Chapter 173-460 WAC addresses requirements for new sources of toxic air pollutants. Agency staff participated in the stakeholder process for the revisions to chapter 173-460 WAC and recommended adopting the updated changes into our incorporation by reference section of the agency's new source review program, with the same exclusions previously adopted for chapter 173-460 WAC references.

Citation of Rules Affected by this Order: Amending Regulation I, Section 6.01 (Components of New Source Review Program).

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 20-05-093 on February 19, 2020.

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 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: July 23, 2020.

Craig T. Kenworthy
Executive Director

AMENDATORY SECTION
SECTION 6.01 COMPONENTS OF NEW SOURCE REVIEW PROGRAM

(a) In addition to the provisions of this regulation, the Agency adopts by reference and enforces the following provisions of the new source review program established by the Washington State Department of Ecology:

WAC 173-400-030 Definitions. (effective 12/29/12)

WAC 173-400-081 Startup and shutdown. (effective 4/01/11)

WAC 173-400-110 New source review (NSR) for sources and portable sources. (effective 12/29/12) (1)(c)(i), (1)(d) and (1)(e)

WAC 173-400-111 Processing notice of construction applications for sources, stationary sources and portable sources. (effective 7/01/16)

WAC 173-400-112 Requirements for new sources in nonattainment areas. (effective 12/29/12)

WAC 173-400-113 Requirements for new sources in attainment or unclassifiable areas. (effective 12/29/12)

WAC 173-400-114 Requirements for replacement or substantial alteration of emission control technology at an existing stationary source. (effective 12/29/12)

WAC 173-400-117 Special protection requirements for federal Class I areas. (effective 12/29/12)

WAC 173-400-171 Public notice. (effective 7/01/16)

WAC 173-400-200 Creditable stack height and dispersion techniques. (effective 2/10/05)

WAC 173-400-560 General order of approval. (effective 12/29/12)

WAC 173-400-700 Review of major stationary sources of air pollution. (effective 4/01/11)

WAC 173-400-710 Definitions. (effective 7/01/16)

WAC 173-400-720 Prevention of significant deterioration (PSD). (effective 7/01/16)

WAC 173-400-730 Prevention of significant deterioration application processing procedures. (effective 7/01/16)

WAC 173-400-740 PSD permitting public involvement requirements. (effective 7/01/16)

WAC 173-400-750 Revisions to PSD permits. (effective 12/29/12)

WAC 173-400-800 Major stationary source and major modification in a nonattainment area. (effective 4/01/11)

WAC 173-400-810 Major stationary source and major modification definitions. (effective 7/01/16)

WAC 173-400-820 Determining if a new stationary source or modification to a stationary source is subject to these requirements. (effective 12/29/12)

WAC 173-400-830 Permitting requirements. (effective 7/01/16)

WAC 173-400-840 Emission offset requirements. (effective 7/01/16)

WAC 173-400-850 Actual emissions plantwide applicability limitation (PAL). (effective 7/01/16)

WAC 173-400-860 Public involvement procedures. (effective 4/01/11)

WAC 173-460-020 Definitions. (effective 6/20/09)

WAC 173-460-030 Applicability. (effective 6/20/09)

WAC 173-460-040 (2)-(3) New source review. (effective 12/23/19 ((~~6/20/09~~)))

WAC 173-460-050 Requirement to quantify emissions. (effective 6/20/09)

WAC 173-460-060(1) Control technology requirements. (effective 6/20/09)

WAC 173-460-070 Ambient impact requirement. (effective 6/20/09)

WAC 173-460-071 Voluntary limits on emissions. (effective 6/20/09)

WAC 173-460-080 (2)-(4) First tier review. (effective 12/23/19 ((~~6/20/09~~)))

WAC 173-460-090 Second tier review. (effective 6/20/09)

WAC 173-460-100 Third tier review. (effective 6/20/09)

WAC 173-460-150 Table of ASIL, SQER and de minimis emission values. - excluding references to de minimis emission values (effective 12/23/19 ((~~6/20/09~~)))

(b) The Washington State Department of Ecology is the permitting agency for the Prevention of Significant Deterioration (PSD) program under WAC 173-400-700 through WAC 173-400-750 (as delegated by agreement with the US Environmental Protection Agency, Region 10), and for primary aluminum smelters, kraft pulp mills, and sulfite pulp mills.

(c) The Washington State Department of Health is the permitting agency for radionuclides under chapter 246-247 WAC.

(d) The Energy Facility Site Evaluation Council (EFSEC) is the permitting agency for large natural gas and oil pipelines, electric power plants above 350 megawatts, new oil refineries or large expansions of existing facilities, and underground natural gas storage fields under chapter 463-78 WAC.

WSR 20-16-027
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed July 24, 2020, 11:16 a.m., effective August 24, 2020]

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

Purpose: Clarifies language and adds program review model for career and technical education (CTE) B&I and CTE administrator programs. Currently no model is written in rule for reviewing these programs.

Citation of Rules Affected by this Order: Amending WAC 181-78A-100.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Adopted under notice filed as WSR 20-12-054 on May 29, 2020.

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 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: July 23, 2020

Maren Johnson
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-17-089, filed 8/14/18, effective 9/14/18)

WAC 181-78A-100 Existing approved programs. Providers of programs approved by the board shall comply with the review process established in this chapter and published by the board.

(1) Teacher and principal preparation programs: The board will annually review performance data of all educator preparation programs based on components and indicators established in this chapter and published by the board. The professional educator standards board will provide annual updated written guidance to providers regarding the submission of annual program data.

(a) Notification: If annual preparation program data analysis indicates that program performance falls below thresholds during any given review period, the board staff will provide written notification to the educator preparation program provider. The educator preparation program provider may choose to submit a response to the board staff. The response must be received by board staff within four weeks following receipt of the notification by the provider. The response should offer evidence of factors and circumstances that explain why program performance is below board approved thresholds on the indicators identified in the notice. The board staff will offer providers guidance on content and timelines for submission of this optional response. The board will review responses concurrently with annual data analysis reports.

(b) Interventions: Providers with program performance below indicator thresholds are subject to graduated levels of intervention as follows:

(i) Intervention 1 - Required self-study report: If a provider that received written notification of performance below threshold on one or more indicators during the previous review period has performance below thresholds on the same indicator(s) during the subsequent review period, the board will send the provider a second notification. The provider must complete a self-study report related to the components and domain(s) identified in both notifications and submit it to the board. The board will give providers written timelines and guidance for the submission of these materials. In the self-study report, the provider may also submit evidence and a description of the provider's performance related to the indicator(s), components, and domains identified in the notifications. If the board is satisfied with the self-study report, the board will approve it ((~~on the consent agenda of the~~)) at a board meeting ((~~following submission~~)). If the board is not satisfied with the self-study report, staff will give providers additional written timelines and guidance to address the board's concerns.

(ii) Intervention 2 - Formal review: If a provider demonstrates performance below thresholds for a third successive review period or more, the professional educator standards board will provide a third notification. Based on its discretion and authorized by a vote, the board also may require a formal review related to the provider's performance in the domains of practice identified in the notifications. Prior to commencing a formal review, the board will consider the notifications, responses, and self-study report to determine whether to proceed with or postpone a formal review.

(A) The formal review will incorporate the following elements:

(I) The board shall determine the schedule for formal reviews and whether an on-site visit or other forms of documentation and validation will be used to evaluate programs under program approval standards.

(II) The provider will submit requested evidence to the board staff.

(III) A review team, including at least one member of the board, will review the evidence. The review team may request additional information including information provided through interviews with provider staff or affiliates as needed.

(IV) The review team will provide a report to the board identifying areas of practice associated with the previous notifications where the provider is out of compliance with educator preparation program requirements established in WAC 181-78A-300 and the educator preparation program expectations and outcomes established in WAC 181-78A-220. The review team may also identify areas of practice where the provider is out of compliance with educator preparation program requirements that were not associated with previous notifications but were noticed by the review team during the process of review. The report may also identify whether the approved indicators or thresholds are functioning as intended.

(V) Board staff serving on the review team will provide assistance to the review team during the review process but will not serve in an evaluative role.

(VI) The review team will submit its report and other appropriate documentation to the provider and the board within one year of the board designating the program for formal review.

(VII) The board may extend the length of the one-year period for submission of the review team's report up to two years at its discretion.

(B) Providers may submit a reply to the review team report within two weeks following receipt of the report. The reply is to focus on the evidence, conclusions, and recommendations in the report but also may include additional evidence of factors and circumstances that explain why program performance is persistently below board approved thresholds on the indicators identified in the notice and self-study report.

The board shall publish the process for submitting and reviewing the reply.

(C) In considering the review team's report, the board may request additional information or review, or take action to extend, or change the program's approval status per the provisions of WAC 181-78A-110.

(c) A provider may request a hearing in instances where it disagrees with the board's decision to extend or change the program's approval status. ((~~This request must be made within twenty days from the decision date.~~)) The hearing will be conducted through the office of administrative hearings by an administrative law judge per chapter 34.05 RCW and will adhere to the process of brief adjudicated hearings. The provider seeking a hearing will provide a written request to the professional educator standards board in accordance with WAC 10-08-035 no more than thirty calendar days from the decision date.

(d) The board will publish a schedule for its review of the domains, components, indicators and thresholds. This review will occur at least every five years and not more frequently than every two years.

(2) Superintendent programs: The board will annually review data related to the performance of all superintendent programs according to data reporting guidance published by the board.

(a) Annual data analysis: After each annual review period, the board will give superintendent program providers written analysis of the program's annual data submission.

(b) Superintendent program review: The professional educator standards board shall determine the schedule for formal reviews and whether an on-site visit or other forms of documentation and validation shall be used for evaluation.

(i) Superintendent program reviews will be conducted at least every five years and not more frequently than every three years.

(ii) Superintendent program providers will submit requested evidence to the staff of the professional educator standards board.

(iii) A review team, including at least one member of the professional educator standards board, will review the evidence and request additional information including information provided through interviews with provider staff or affiliates as needed. One board staff member will serve on the review team to provide assistance to the review team during the review process but will not serve in an evaluative role. Additional members of the review team shall include at least one ((~~K-12~~)) P-12 practitioner with expertise related to the program scheduled for review and two individuals with expertise related to the domains of practice identified in annual written analyses.

(iv) One of the two providers with peer representatives on the review team will be scheduled for annual review during the subsequent review period.

(v) At least three months in advance of scheduled review, superintendent program providers must complete a self-study report related to the components and domain(s) identified in the written analyses of annual data submissions. The board will give providers written timelines and guidance for the submission of these materials. In the self-study report, the provider may also provide evidence and a description of the provider's performance related to the indicator(s), components, and domains identified in the notifications. Evidence shall include such data and information from the annual data submissions required per WAC 181-78A-255(2) as have been designated by the board as evidence pertinent to the program approval process.

(c) Following the review, the review team will provide a report identifying any areas where the program is out of compliance with requirements established in WAC 181-78A-300 and the program expectations and outcomes established in WAC 181-78A-220.

(i) The report may also verify or contradict that the approved indicators or thresholds are functioning as intended.

(ii) The board may extend the length of the one-year report period up to two years at its discretion. The review team's report and other appropriate documentation will be submitted to the provider and the board within one year of the board designating the program for formal review.

(iii) Providers may submit a reply to the review team report within two weeks following receipt of the report. The reply is limited to evidence that the review disregarded state standards, failed to follow state procedures for review, or failed to consider evidence that was available at the time of the review. The board shall publish the process for submitting and reviewing the reply.

(iv) In considering the review team's report, the board may request additional information or review, or take action to extend or change the educator preparation program's approval status per the provisions of WAC 181-78A-110.

(d) A provider may request a hearing in instances where it disagrees with the professional educator standards board's decision((~~. This request must be made within twenty days from the decision date~~)) to extend or change the program's approval status. The hearing will be conducted through the office of administrative hearings by an administrative law judge per chapter 34.05 RCW and will adhere to the process of brief, adjudicated hearings. The provider seeking a hearing will provide a written request to the board in accordance with WAC 10-08-035 no more than thirty calendar days from the decision date.

(3) Program administrator programs: The board will annually review data related to the performance of all program administrator programs according to data and reporting guidelines published by the board.

(a) Program administrator programs implemented in conjunction with principal preparation programs will be reviewed concurrently with that provider's principal preparation program.

(b) Program administrator programs implemented in conjunction with superintendent preparation programs will be reviewed concurrently with that provider's superintendent preparation program.

(4) School counseling programs. ((~~The board will approve school counseling programs upon receiving notification of the program's approval from the council for the accreditation for counseling and related education programs.~~)) School counseling program providers shall comply with accrediting procedures for council for the accreditation for counseling and related education programs, unless the

program has been specifically approved to operate under alternative national standards per WAC 181-78A-225.

(a) A provider of residency school counseling programs without approval from council for the accreditation for counseling and related education programs shall provide proof to the professional educator standards board ((~~before November 1, 2018,~~)) that it will seek such accreditation((~~. The board will place any existing school counseling program that does not receive council for the accreditation for counseling and related education programs accreditation before November 1, 2022, into disapproval status~~)), unless the program has been specifically approved to operate under alternative national standards per WAC 181-78A-225.

(b) The board will place any existing approved residency school counseling program not accredited from the council for the accreditation for counseling and related education programs into disapproval status on November 1, 2022, unless the program provider produces evidence of seeking such accreditation, or unless that program has been specifically approved to operate under alternative national standards per WAC 181-78A-225.

(((~~(c) Providers of existing residency school counseling programs without accreditation from the council for the accreditation for counseling and related education programs may continue providing courses and field experience that lead to the residency school counselor certificate if the candidates in their programs pass a licensure exam and complete a Master's degree in any area of counseling from a CACREP-accredited program with at least forty-eight semester or seventy-two quarter hours of graduate-level academic credit covering at the minimum the following six content areas:~~

~~(i) Appraisal of individuals;~~

~~(ii) Group counseling;~~

~~(iii) Cultural diversity in counseling;~~

~~(iv) Career development;~~

~~(v) Fundamentals of school counseling;~~

~~(vi) Practicum/internship: Candidates complete a supervised internship in a school based setting that includes a minimum of four hundred hours of on-the-job professional service and one hour per week of individual supervision provided by a mentor.~~))

(5) School psychology programs. Providers of school psychology programs shall comply with accrediting procedures for the National Association for School Psychology. ((~~Approval from the professional educator standards board will be based upon the program receiving approval from~~)) School psychology program providers shall comply with accrediting procedures for the National Association for School Psychology, unless the program has been specifically approved to operate under alternative national standards per WAC 181-78A-225.

(a) A provider of school psychology programs without approval from the National Association for School Psychology shall provide proof to the professional educator standards board that it will seek such accreditation, unless the program has been specifically approved to operate under alternative national standards per WAC 181-78A-225.

(b) The board will place any existing approved school psychology program not accredited from the National Association of School Psychology into disapproval status on November 1, 2022, unless the program provider produces evidence of seeking such accreditation, or unless that program has been specifically approved to operate under alternative national standards per WAC 181-78A-225.

(6) Career and technical education administrator and business and industry route educator preparation programs: The board will annually review data related to the performance of all such programs according to data reporting guidance published by the board.

(a) Annual data analysis: After each annual review period, the board will give career and technical education administrator and business and industry route educator preparation program providers written analysis of the program's annual data submission.

(b) Career and technical education administrator and business and industry route educator preparation program review: The board shall determine the schedule, format, and which forms of documentation and validation shall be used to evaluate programs.

(i) Career and technical education administrator and business and industry route educator preparation program reviews will be conducted at least every five years and not more frequently than every three years.

(ii) At least three months in advance of their scheduled review, career and technical education administrator and business and industry route educator preparation program providers must complete a self-study report related to the components and domain(s) identified in the written analyses of annual data submissions. The board will give providers written timelines and guidance for the submission of these materials.

(iii) Career and technical education administrator and business and industry route educator preparation program providers will submit requested evidence to the staff of the professional educator standards board. Evidence shall include such data and information from the annual data submissions required per WAC 181-78A-235(3) as have been designated by the board as evidence pertinent to the program approval and review processes.

(iv) A review team will review the evidence and request additional information including information provided through documents and interviews with program provider staff or affiliates as needed. One board staff member will serve as chair on the review team during the review process but will not serve in an evaluative role. Additional members of the review team shall include one member of the program's professional educator advisory board, one P-12 practitioner with expertise in career and technical education related to the program scheduled for review, and two representatives of peer programs. Any two of these review team members, or two additional members, must be identified individuals with expertise related to the domains of practice and standard components identified in annual written program feedback analyses or in the program's self-study report. One of the two providers with peer representatives on the review team will be scheduled for the subsequent program review.

(v) The review team will use multiple data sources to address the specific goals listed in this section.

(A) The review team and the preparation program provider will use the self-study report to identify program provider's goals and strategies for improvement.

(B) The review team and the preparation program provider will use preparation program data available at the time of review.

(C) The review team and the preparation program provider will use evidence compiled by the provider that demonstrates performance aligned with all program standards and requirements. Staff of the board will offer program providers guidance regarding the evidence required, how it may be gathered and used, and how it must be submitted.

(vi) The review team will use available evidence to write the review report that will be used by the board in consideration of continued approval status.

(c) Following the review, the review team will provide a report identifying any areas of practice in which program performance is out of alignment with standards and requirements.

(i) The review team's report and other appropriate documentation will be submitted to the provider and the board within six months of the formal review.

(ii) Providers may submit a reply to the review team report within three weeks following receipt of the report. The board shall publish the process for submitting and reviewing the reply.

(iii) In considering the review team's report, the board may request additional information for review, or take action to extend or change the educator preparation program's approval status.

(iv) Based upon the review team's report, the program provider's response, and any subsequent requests for information, as applicable, the board shall take one of the following actions:

(A) The board shall give full approval as described in WAC 181-78A-110 (1)(a).

(B) Limited approval as described in WAC 181-78A-110 (1)(b).

(C) Disapproval as described in WAC 181-78A-110 (1)(c).

(v) A provider may request a hearing in instances where it disagrees with the board's decision to extend or change the program's approval status. The hearing will be conducted through the office of administrative hearings by an administrative law judge per chapter 34.05 RCW and will adhere to the process of brief adjudicated hearings. The provider seeking a hearing will provide a written request to the professional educator standards board in accordance with WAC 10-08-035 no more than thirty calendar days from the decision date.

WSR 20-16-030
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed July 25, 2020, 10:39 a.m., effective August 25, 2020]

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

Purpose: This WAC amendment provides for a one-year multiple measures pilot for the edTPA. This multiple measures pilot process allows for greater flexibility for pathways into the profession.

Citation of Rules Affected by this Order: New WAC 181-78A-340.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Adopted under notice filed as WSR 20-12-067 on July 16, 2020 [June 1, 2020].

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: July 23, 2020.

Maren Johnson
Rules Coordinator

NEW SECTION

WAC 181-78A-340 Pilot of multiple measures for the teacher performance assessment. (1) Preparation program providers approved in the endorsement areas designated by the professional educator standards board must ensure that their teacher candidates achieve the multiple measures pilot passing score set by the board for the teacher performance assessment.

(2) Candidates who achieve this pilot passing score, but do not achieve the score otherwise set by the board, may be recommended for certification if upon review of one or more multiple measures, the program provider determines the candidate has demonstrated the requisite knowledge and skills.

(3) Preparation program providers may use one or more of the following multiple measures as the basis for their review:

(a) Observation of practice in the role as documented by the mentor teacher or the preparation program provider;

(b) Evidence submitted by the candidate to the program provider in the areas of planning, instruction, or student assessment;

(c) Coursework; or

(d) Other measures as determined by the program provider.

(4) Program providers may recommend a candidate for certification if they determine the candidate has the requisite knowledge and skills, and the candidate has met all other requirements for program completion. Candidates may be

recommended under this section until a date as determined by the professional educator standards board.

(5) Preparation programs in the indicated endorsement areas may choose to not participate in this pilot, and require the passing score otherwise set by the board.

(6) Preparation program providers participating in this pilot must report requested data to the professional educator standards board by the dates set by the professional educator standards board.

WSR 20-16-031
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed July 25, 2020, 10:40 a.m., effective August 25, 2020]

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

Purpose: Allows all state approved educator preparation programs to be eligible to serve as clock hour providers. This rule would allow approved preparation programs who are not able to issue credits to issue clock hours.

Citation of Rules Affected by this Order: Amending WAC 181-85-045.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Adopted under notice filed as WSR 20-12-059 on July 16, 2020 [May 29, 2020].

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 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: July 23, 2020.

Maren Johnson
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-15-143, filed 7/24/19, effective 8/24/19)

WAC 181-85-045 Approved in-service education agency—Definition. As used in this chapter, the term "approved in-service education agency" shall mean an agency approved by the professional educator standards board to provide in-service education programs and to grant continuing education credit hours to all or a selective group of educators. Such agency must demonstrate the following characteristics:

(1) The agency is one of the following entities or a department or section within such entities:

(a) A college or university referenced in WAC 181-85-025(1);

(b)(i) An organization which for the purpose of this chapter shall mean any local, state, regional, or national organization which offers in-service education programs to teachers, administrators, ((~~and/or~~)) educational staff associates, or paraeducators. These organizations must be nonprofit or not-for-profit organizations;

(ii) Organizations shall provide documentation of their nonprofit or not-for-profit status to the superintendent of public instruction as part of their annual assurances of compliance with program and recordkeeping standards under WAC 181-85-210.

(c) A school district, an educational service district, the superintendent of public instruction, or any local, state, or federal agency; ((~~or~~))

(d) An approved private school which for the purpose of this chapter shall mean the same as provided in WAC 180-90-112; or

(e) An educator preparation program provider approved under chapter 181-78A or 181-77A WAC by the professional educator standards board.

(2) The in-service education agency has either a committee or board of directors that provide prior approval to proposed in-service education programs on the basis that the proposed programs are designed to meet the program standards set forth in WAC 181-85-200, and the content standards in WAC 181-85-202.

The committee will be composed of individuals who may include teachers, educational staff associates, administrators, paraeducators, community members, or representatives from colleges and universities.

WSR 20-16-032
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed July 25, 2020, 10:43 a.m., effective August 25, 2020]

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

Purpose: Because of school closures relating to the current public health situation, it is very challenging for educators to meet the clock hour and assessment requirements for their certificates. This WAC amendment extends certificate expiration dates for one year.

Citation of Rules Affected by this Order: New WAC 181-79A-118.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Adopted under notice filed as WSR 20-12-053 on July 16, 2020 [May 29, 2020].

Changes Other than Editing from Proposed to Adopted Version: In subsection (3) of WAC 181-79A-118, the language was changed to allow all certificates expiring June 30, 2021, to be renewed at any point prior to that date, as long as all certificate renewal requirements had been met.

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 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: July 23, 2020.

Maren Johnson
Rules Coordinator

NEW SECTION

WAC 181-79A-118 Expiration and lapse dates of certificates. (1) Certificates scheduled to expire June 30, 2020, under WAC 181-79A-117, or scheduled to lapse June 30, 2020, under WAC 181-85-100, excluding residency certificates that are subject to reissuance, are scheduled to expire or lapse June 30, 2021.

(2) Certificates scheduled to expire June 30, 2020, under WAC 181-79A-117, or scheduled to lapse June 30, 2020, under WAC 181-85-100, may have already been renewed. For these renewed certificates, the expiration or lapse date will be calculated as if the certificate expiring June 30, 2020, had an expiration or lapse date of June 30, 2021.

(3) Applications for renewal of certificates scheduled to expire June 30, 2021, may be submitted at any point prior to the June 30, 2021, expiration date.

(4) Limited certificates under WAC 181-79A-231, 181-77-014, and 181-77-081 expire as described in those sections.

(5) Permits under WAC 181-01-001, 181-02-001, 181-79A-128, and 181-79A-224 expire as described in those sections. Permits for candidates eligible under those sections which expired beginning July 1, 2019, and before December 31, 2020, may be reissued once for one additional year.

WSR 20-16-033
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed July 25, 2020, 10:44 a.m., effective August 25, 2020]

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

Purpose: Allows approved preparation program providers to review a candidate's learning and experience, and then waive or reduce the requisite clinical practice and coursework if they determine the candidate has the required knowledge and skills. Schools have closed due to public health concerns, making it very challenging to complete clinical practice and coursework.

Citation of Rules Affected by this Order: New WAC 181-78A-027.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Adopted under notice filed as WSR 20-12-056 on July 16, 2020 [May 29, 2020].

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 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: July 23, 2020.

Maren Johnson
Rules Coordinator

NEW SECTION

WAC 181-78A-027 Waiver of clinical practice and course work by a preparation program provider. (1) Based on review of current educational settings, and review of a candidate's previous course work, field experiences, work experiences, and alternative learning experiences, an educator preparation program provider may waive or reduce in length the required clinical practice, and/or waive required course work, if based on the review the provider determines that the candidate has the knowledge and skills to be otherwise gained from the required clinical practice or course work.

(2) Under this section, educator preparation program providers may waive or reduce in length the required clinical practice and/or course work through June 30, 2021.

WSR 20-16-034
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed July 25, 2020, 10:45 a.m., effective August 25, 2020]

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

Purpose: Washington state approved teacher preparation programs may recommend candidates for an emergency certificate if they have met all program completion requirements with the exception of one or more of the assessment requirements. Testing centers are now closed due to public health reasons, and it is very challenging to complete the assess-

ments. This allows individuals to serve in the role of teacher for one year, allowing them to complete their assessment requirements.

Citation of Rules Affected by this Order: New WAC 181-79A-228.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Adopted under notice filed as WSR 20-12-055 on July 16, 2020 [May 29, 2020].

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 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: July 23, 2020.

Maren Johnson
Rules Coordinator

NEW SECTION

WAC 181-79A-228 Emergency teacher certificates. Emergency teacher certificates, valid for one year, may be issued by the superintendent of public instruction under the following conditions:

(1) A teacher preparation program approved by the professional educator standards board has recommended the candidate as having met all requirements for program completion with the exception of one or more of the following:

(a) The performance assessment as described in WAC 181-78A-232 and 181-78A-300;

(b) The content knowledge assessment as described in WAC 181-78A-300 (2)(b); and

(c) The basic skills assessment as described in WAC 181-78A-232 and 181-78A-300.

(2) During the validity period of the certificate, preparation program providers are required to inform, advise, and support applicants on assessment requirements as described in WAC 181-78A-231(3).

(3) Teacher preparation programs may recommend candidates for an emergency certificate under this section through June 30, 2021.

(4) One additional one-year emergency certificate may be issued upon recommendation by the preparation program provider. Teacher preparation programs may recommend candidates for this additional one-year emergency certificate through December 31, 2021.

WSR 20-16-044
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed July 27, 2020, 1:12 p.m., effective August 27, 2020]

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

Purpose: Amendments to chapter 388-280 WAC clarify the role and functions of the United States Department of Health and Human Services (HHS) in eligibility for repatriation services, align repatriation rules with the Washington state emergency repatriation plan, distinguish between emergency and nonemergency repatriation assistance, fix incorrect cross-references, and spell out abbreviations for clarity.

Citation of Rules Affected by this Order: Amending WAC 388-280-0010, 388-280-0020, 388-280-0030, 388-280-0040, 388-280-0050, and 388-280-0060.

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

Adopted under notice filed as WSR 20-12-040 on May 27, 2020.

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 0, Amended 6, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 6, Repealed 0.

Date Adopted: July 27, 2020.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 00-19-077, filed 9/19/00, effective 11/1/00)

WAC 388-280-0010 What is the United States Repatriation Program? The United States Repatriation Program ((~~assists a~~)) provides temporary assistance to U.S. ((~~citizen or dependent~~)) citizens and dependents who ((~~is:~~

(~~1) Without~~)) are brought from a foreign country to the United States because of lack of financial resources((~~; and~~

(~~2) Returned or brought back to the U.S. from a foreign country because of:~~

(~~a) Mental illness; or~~

(~~b) Destitution, physical illness, or a~~)), illness, war, threat of war, natural disaster, or similar crisis ((~~such as war~~)).

"Assistance" means non-emergency benefits and services. "Emergency" means an activation of the state emergency repatriation plan. During an emergency, you may get

emergency assistance at an emergency repatriation center when you arrive at a port of entry. Benefits and services available during an emergency depend on what is available at the time of incident. You may apply for non-emergency assistance in your state of final destination after receiving assistance at an emergency repatriation center.

For the purposes of this chapter, "we" and "us" means the department of social and health services.

AMENDATORY SECTION (Amending WSR 00-19-077, filed 9/19/00, effective 11/1/00)

WAC 388-280-0020 How do I apply for repatriation assistance? You apply for repatriation assistance by contacting the U.S. ((~~State~~)) department of health and human services (HHS) or us.

(1) If you contact ((~~the U.S. State Department~~)) HHS, we consider a referral from them as an approved application.

(2) If you contact us directly, we apply for you to ((~~the U.S. Department of Health and Human Services (HHS)~~)) HHS.

(3) During an emergency, repatriation assistance is provided to you at an emergency repatriation center at a port of entry in Washington state.

AMENDATORY SECTION (Amending WSR 00-19-077, filed 9/19/00, effective 11/1/00)

WAC 388-280-0030 Do I have to repay the repatriation assistance? Repatriation assistance is a loan. You, or your representative if you are ((~~mentally ill~~)) incapacitated, must:

(1) Sign a statement recognizing repatriation assistance as a loan; and

(2) Agree to repay the funds.

Repayment goes to the U.S. department of health and human services (HHS), and HHS is responsible for collecting repayment of this loan.

AMENDATORY SECTION (Amending WSR 00-19-077, filed 9/19/00, effective 11/1/00)

WAC 388-280-0040 Are there limits to my income and resources? (1) You are ((~~ineligible~~)) not eligible to receive ((~~repatriate~~)) repatriation assistance if ((~~you have nonexempt~~)) your:

(a) Income, as defined by temporary assistance for needy families (TANF) equal to or greater than the TANF need standards as described in WAC ((~~388-450-0005~~)) 388-478-0015; or

(b) Resources, as defined by TANF under WAC 388-470-0005 that are available to meet your resettlement needs.

(2) We consider a resource available to you when:

(a) The value can be determined;

(b) It is controlled by you; and

(c) You can use the resource to meet your needs.

(3) Income limits do not apply during emergency repatriation incidents as defined in the Washington state Emergency Repatriation Plan.

AMENDATORY SECTION (Amending WSR 00-19-077, filed 9/19/00, effective 11/1/00)

WAC 388-280-0050 How long can I receive repatriation assistance? (1) If you are ((~~mentally ill~~)) incapacitated, you receive temporary care until you:

(a) Can be released to the care of a relative or state agency; or

(b) Are discharged or granted release from hospitalization.

(2) If you are not ((~~mentally ill~~)) incapacitated, you may receive repatriation assistance up to twelve months as follows:

(a) "Temporary assistance" meaning repatriation assistance provided during the first ninety days after you return to the United States.

(b) "Extended assistance" meaning repatriation assistance provided for up to nine months after the end of your temporary assistance. We must have approval in advance from ((~~HHS~~)) the U.S. department of health and human services (HHS), so you must ask us to apply for extended assistance while receiving temporary assistance and be:

(i) Ineligible for any other assistance program; and

(ii) Unable to support or care for yourself due to age, illness, or lack of job skills.

(3) During an emergency, you may only receive repatriation assistance as long as you remain in the emergency repatriation center. Once you leave the emergency repatriation center, you may apply for non-emergency repatriation assistance.

AMENDATORY SECTION (Amending WSR 00-19-077, filed 9/19/00, effective 11/1/00)

WAC 388-280-0060 What services are available to me under the repatriation program? (1) The ((~~HHS~~)) U.S. department of health and human services (HHS) sets limits on how much we pay for repatriation assistance. ((~~The limits are:~~

~~(a) The temporary assistance for needy families (TANF) payment standards under WAC 388-478-0015 for goods and services to meet basic needs;~~

~~(b) Up to five hundred sixty dollars per person to meet resettlement costs, if necessary, and for only one month while you receive temporary assistance.~~))

(2) Within payment limits, repatriation assistance includes:

(a) Travel to your place of residence, limited to:

(i) One domestic trip at the lowest fare and using the most direct means;

(ii) Meals and lodging while you are traveling;

(iii) Money for incidentals; and

(iv) If you are ((~~ill or disabled~~)) incapacitated, travel expenses for an escort.

(b) Goods and services necessary for your health and welfare, including:

(i) Transportation for medical treatment, hospitalization or social services;

(ii) Temporary shelter;

(iii) Meals;

(iv) Clothing;

(v) Hospitalization to treat mental or acute illness or other medical care; and

(vi) Guidance, counseling and other social services.

(((~~(c) Resettlement costs, including:~~

~~(i) Utility or housing deposits; and~~

~~(ii) Basic household goods, such as cookware or blankets.~~))

(3) Benefits, services, and assistance available during an emergency at an emergency repatriation center are described in the Washington state Emergency Repatriation Plan.

WSR 20-16-052
PERMANENT RULES
ENERGY FACILITY SITE EVALUATION COUNCIL

[Filed July 28, 2020, 10:05 a.m., effective August 28, 2020]

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

Purpose: The energy facility site evaluation council's purpose for this rule making is to: (1) Assure [ensure] consistency with department of ecology rules (RCW 70.94.422); (2) to assure [ensure] consistency and compliance with federal rules; and (3) to provide clarifying language in the existing rules.

Citation of Rules Affected by this Order: Amending WAC 463-78-005.

Statutory Authority for Adoption: RCW 80.50.040(1); and chapter 34.05 RCW.

Other Authority: RCW 70.94.422.

Adopted under notice filed as WSR 20-11-082 on May 20, 2020.

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 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: July 28, 2020.

Sonia Bumpus
Manager

AMENDATORY SECTION (Amending WSR 19-16-025, filed 7/26/19, effective 8/26/19)

WAC 463-78-005 Adoption by reference. (1) The energy facility site evaluation council adopts by reference the ((~~following~~)) provisions ((~~of chapter 173-400 WAC,~~)) in the chapters listed below in this section and the federal rules in WAC 463-78-115 as it existed on November ((~~25, 2018, with the exceptions that:~~)) 11, 2019.

(2) The energy facility site evaluation council adopts by reference the following provisions of chapter 173-400 WAC in effect on the date in subsection (1) of this section with the following exceptions:

(a) These provisions are not adopted by reference:

(i) WAC 173-400-111 (5)(a) (last six words), (6), (9)((~~,~~));

(ii) WAC 173-400-730(4)((~~, and~~));

(iii) WAC 173-400-750(2) second sentence ((~~are not adopted by reference~~)); and

(iv) The adoption date shall be November 11, 2019.

(b) The terms "ecology," "authority," "director," and "permitting authority" in WAC 173-400-030 shall mean "the energy facility site evaluation council" unless a different meaning is plainly required by the context.

WAC 173-400-025:	Adoption of federal rules.
WAC 173-400-030:	Definitions.
WAC 173-400-036:	Relocation of portable sources.
WAC 173-400-040:	General standards for maximum emissions.
WAC 173-400-050:	Emission standards for combustion and incineration units.
WAC 173-400-060:	Emission standards for general process units.
WAC 173-400-075:	Emission standards for sources emitting hazardous air pollutants.
WAC 173-400-081:	Emission limits during startup and shutdown.
WAC 173-400-091:	Voluntary limits on emissions.
WAC 173-400-105:	Records, monitoring, and reporting.
WAC 173-400-107:	Excess emissions.
WAC 173-400-110:	New source review (NSR) for sources and portable sources.
WAC 173-400-111:	Processing notice of construction applications for sources, stationary sources and portable sources.
WAC 173-400-112:	Requirements for new sources in nonattainment areas.
WAC 173-400-113:	Requirements for new sources in attainment or unclassifiable areas.
WAC 173-400-114:	Requirements for replacement or substantial alteration of emission control technology at an existing stationary source.
WAC 173-400-116:	Increment protection.
WAC 173-400-117:	Special protection requirements for federal Class I areas.
WAC 173-400-120:	Bubble rules.

WAC 173-400-131:	Issuance of emission reduction credits.
WAC 173-400-136:	Use of emission reduction credits (ERC).
WAC 173-400-161:	Compliance schedules.
WAC 173-400-171:	Public notice and opportunity for public comment.
WAC 173-400-175:	Public information.
WAC 173-400-180:	Variance.
WAC 173-400-190:	Requirements for nonattainment areas.
WAC 173-400-200:	Creditable stack height and dispersion techniques.
WAC 173-400-205:	Adjustment for atmospheric conditions.
WAC 173-400-700:	Review of major stationary sources of air pollution.
WAC 173-400-710:	Definitions.
WAC 173-400-720:	Prevention of significant deterioration (PSD).
WAC 173-400-730:	Prevention of significant deterioration application processing procedures.
WAC 173-400-740:	PSD permitting public involvement requirements.
WAC 173-400-750:	Revisions to PSD permits.
WAC 173-400-800:	Major stationary source and major modification in a nonattainment area.
WAC 173-400-810:	Major stationary source and major modification definitions.
WAC 173-400-820:	Determining if a new stationary source or modification to a stationary source is subject to these requirements.
WAC 173-400-830:	Permitting requirements.
WAC 173-400-840:	Emission offset requirements.
WAC 173-400-850:	Actual emissions plantwide applicability limitation (PAL).
WAC 173-400-860:	Public involvement procedures.

((~~(2)~~)) (3) The energy facility site evaluation council adopts by reference the following provisions of chapter 173-401 WAC, ((~~as it existed on September 16, 2018~~)) in effect on the date referenced in subsection (1) of this section, with the ((~~exception that~~)) following exceptions:

(a) WAC 173-401-620 (2)(i) is not adopted by reference((~~,~~)); and

(b) The terms "ecology," "authority," "director," and "permitting authority" shall mean "the energy facility site evaluation council" unless a different meaning is plainly required by the context.

WAC 173-401-100:	Program overview.
WAC 173-401-200:	Definitions.
WAC 173-401-300:	Applicability.
WAC 173-401-500:	Permit applications.
WAC 173-401-510:	Permit application form.
WAC 173-401-520:	Certification.
WAC 173-401-530:	Insignificant emission units.
WAC 173-401-531:	Thresholds for hazardous air pollutants.
WAC 173-401-532:	Categorically exempt insignificant emission units.
WAC 173-401-533:	Units and activities defined as insignificant on the basis of size or production rate.
WAC 173-401-600:	Permit content.
WAC 173-401-605:	Emission standards and limitations.
WAC 173-401-610:	Permit duration.
WAC 173-401-615:	Monitoring and related recordkeeping and reporting requirements.
WAC 173-401-620:	Standard terms and conditions.
WAC 173-401-625:	Federally enforceable requirements.
WAC 173-401-630:	Compliance requirements.
WAC 173-401-635:	Temporary sources.
WAC 173-401-640:	Permit shield.
WAC 173-401-645:	Emergency provision.
WAC 173-401-650:	Operational flexibility.
WAC 173-401-700:	Action on application.
WAC 173-401-705:	Requirement for a permit.
WAC 173-401-710:	Permit renewal, revocation and expiration.
WAC 173-401-720:	Administrative permit amendments.
WAC 173-401-722:	Changes not requiring permit revisions.
WAC 173-401-725:	Permit modifications.
WAC 173-401-730:	Reopening for cause.
WAC 173-401-750:	General permits.
WAC 173-401-800:	Public involvement.
WAC 173-401-810:	EPA Review.
WAC 173-401-820:	Review by affected states.

(((~~(3)~~))) (4) The energy facility site evaluation council adopts by reference the following provisions of chapter 173-406 WAC, ((~~as it existed on March 1, 2005~~)) in effect on the date referenced to in subsection (1) of this section.

Part I - GENERAL PROVISIONS

WAC 173-406-100:	Acid rain program general provisions.
WAC 173-406-101:	Definitions.
WAC 173-406-102:	Measurements, abbreviations, and acronyms.
WAC 173-406-103:	Applicability.
WAC 173-406-104:	New units exemption.
WAC 173-406-105:	Retired units exemption.
WAC 173-406-106:	Standard requirements.

Part II - DESIGNATED REPRESENTATIVE

WAC 173-406-200:	Designated representative.
WAC 173-406-201:	Submissions.
WAC 173-406-202:	Objections.

Part III - APPLICATIONS

WAC 173-406-300:	Acid rain permit applications.
WAC 173-406-301:	Requirement to apply.
WAC 173-406-302:	Information requirements for acid rain permit applications.
WAC 173-406-303:	Permit application shield and binding effect of permit application.

Part IV - COMPLIANCE PLAN

WAC 173-406-400:	Acid rain compliance plan and compliance options.
WAC 173-406-401:	General.
WAC 173-406-402:	Repowering extensions.

Part V - PERMIT CONTENTS

WAC 173-406-500:	Acid rain permit.
WAC 173-406-501:	Contents.
WAC 173-406-502:	Permit shield.

Part VI - PERMIT ISSUANCE

WAC 173-406-600:	Acid rain permit issuance procedures.
WAC 173-406-601:	General.
WAC 173-406-602:	Completeness.
WAC 173-406-603:	Statement of basis.
WAC 173-406-604:	Issuance of acid rain permits.

Part VII - PERMIT REVISIONS

WAC 173-406-700:	Permit revisions.
WAC 173-406-701:	General.

Part VII - PERMIT REVISIONS

WAC 173-406-702:	Permit modifications.
WAC 173-406-703:	Fast-track modifications.
WAC 173-406-704:	Administrative permit amendment.
WAC 173-406-705:	Automatic permit amendment.
WAC 173-406-706:	Permit reopenings.

Part VIII - COMPLIANCE CERTIFICATION

WAC 173-406-800:	Compliance certification.
WAC 173-406-801:	Annual compliance certification report.
WAC 173-406-802:	Units with repowering extension plans.

Part IX - NITROGEN OXIDES

WAC 173-406-900:	Nitrogen oxides emission reduction program.

Part X - SULFUR DIOXIDE OPT-IN

WAC 173-406-950:	Sulfur dioxide opt-ins.

(((~~(4)~~))) (5) The energy facility site evaluation council adopts by reference the following provisions of chapter 173-460 WAC, ((~~as it existed on June 20, 2009~~)) in effect on the date referenced in subsection (1) of this section.

WAC 173-460-010:	Purpose.
WAC 173-460-020:	Definitions.
WAC 173-460-030:	Applicability.
WAC 173-460-040:	New source review.
WAC 173-460-050:	Requirement to quantify emissions.
WAC 173-460-060:	Control technology requirements.
WAC 173-460-070:	Ambient impact requirement.
WAC 173-460-080:	First tier review.
WAC 173-460-090:	Second tier review.
WAC 173-460-100:	Third tier review.
WAC 173-460-140:	Remedies.
WAC 173-460-150:	Table of ASIL, SQER, and de minimis emission values.

(((~~(5)~~))) (6) The energy facility site evaluation council adopts by reference the following provisions of chapter 173-441 WAC, ((~~as it existed on January 1, 2011~~)) in effect on the date referenced in subsection (1) of this section.

WAC 173-441-010:	Scope.
WAC 173-441-020:	Definitions.
WAC 173-441-030:	Applicability.
WAC 173-441-040:	Greenhouse gases.

WAC 173-441-050:	General monitoring, reporting, recordkeeping and verification requirements.
WAC 173-441-060:	Authorization and responsibilities of the designated representative.
WAC 173-441-070:	Report submittal.
WAC 173-441-080:	Standardized methods and conversion factors incorporated by reference.
WAC 173-441-085:	Third-party verification.
WAC 173-441-086:	Assigned emissions level.
WAC 173-441-090:	Compliance and enforcement.
WAC 173-441-100:	Addresses.
WAC 173-441-110:	Fees.
WAC 173-441-120:	Calculation methods incorporated by reference from 40 C.F.R. Part 98 for facilities.
WAC 173-441-130:	Calculation methods for suppliers.
WAC 173-441-140:	Petitioning ecology to use an alternative calculation method to calculate greenhouse gas emissions.
WAC 173-441-150:	Confidentiality.
WAC 173-441-160:	Ecology to share information with local air authorities and with the energy facility site evaluation council.
WAC 173-441-170:	Severability.

WSR 20-16-057
PERMANENT RULES
SPOKANE REGIONAL CLEAN AIR AGENCY

[Filed July 28, 2020, 2:20 p.m., effective September 1, 2020]

Effective Date of Rule: September 1, 2020.

Purpose: Spokane regional clean air agency (SRCAA) Regulation I establishes the regulatory framework and control strategies to ensure that healthy air quality exists in Spokane County, Washington, including meeting the federal air quality standards. The amendments update Regulation I to meet requirements in chapter 173-400 WAC and the federal new source review regulations to ensure that SRCAA is consistent with state and federal clean air acts while attaining and maintain [maintaining] good air quality and protecting citizens' health.

The amendments will improve clarity, readability, formatting consistency among Articles; improve consistency with state and federal requirements; simplify compliance for the regulated community by adding adoption by reference sections that specify which state and federal rules are adopted by reference; streamline source test provisions; clarify registration program requirements; clarify new source review requirements; simplify portable source permitting process and update public involvement provisions to allow e-noticing; meeting federal enforceability requirements and the EPA's federal requirements for incorporation into the state implementation plan.

Citation of Rules Affected by this Order: New SRCAA Regulation I, Article I, Section 1.05; Article II, Sections 2.16, 2.17, 2.18, 2.19; and Article IV, Section 4.05; repealing SRCAA Regulation I, Section 6.06; and amending SRCAA Regulation I, Article I, Sections 1.01, 1.02, 1.03, 1.04; Article II, Sections 2.01, 2.02, 2.03, 2.04, 2.05, 2.06, 2.07, 2.08, 2.09, 2.10, 2.11, 2.12, 2.13, 2.14, 2.15; Article IV, Sections 4.01, 4.02, 4.03, 4.04; Article V, Sections 5.01, 5.02, 5.03, 5.04, 5.05, 5.06, 5.07, 5.08, 5.09, 5.10, 5.11, 5.12, 5.13, 5.14, 5.15; Article VI, Sections 6.01, 6.02, 6.03, 6.04, 6.05, 6.07, 6.08, 6.09, 6.11, 6.12, 6.13, 6.14, 6.15, 6.17; and Article X, Sections 10.02, 10.06, 10.07, 10.08, 10.11, 10.13.

Statutory Authority for Adoption: RCW 70.94.141.

Adopted under notice filed as WSR 20-07-094 on March 17, 2020.

Changes Other than Editing from Proposed to Adopted Version: The following typographical changes were made:

- Article I, Section 1.04 (A)(123) correcting a typographical error in the definition of "vent": Vent means any opening ~~thought~~ through which air pollutants are exhausted into the ambient air.
- Article II, Section 2.14 (A)(1) correcting a typographical error in the adoption by reference of WAC 173-400-105 Records, monitoring: Exceptions. The following subsections are not adopted by reference 105(3, 4, 6, ~~040(~~8).

The following place saver changes were made:

- Article IV, Section 4.02 (F)(1) was edited to remove the place saver and insert effective date of 9/1/20.
- Article VI, Section 6.06 was edited to remove the place saver and insert the repealed date of 7/9/20 and Resolution No. 20-08.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 5, Amended 39, Repealed 1; 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 6, Amended 58, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 6, Amended 58, Repealed 1.

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

Date Adopted: July 9, 2020.

Margee Chambers

Rule Writer
SIP Planner

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 20-18 issue of the Register.

WSR 20-16-059
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2020-01—Filed July 28, 2020, 2:33 p.m., effective January 1, 2021]

Effective Date of Rule: January 1, 2021.

Purpose: The purpose of this proposal is to amend WAC 182-08-197 to support the public employees benefits board (PEBB) program.

1. Implement PEBB Policy Resolution 2020-04 by amending default elections for an eligible employee who fails to timely elect coverage.

2. Made technical amendments to WAC 182-08-197:

- Added a contracted vendor must receive required forms no later than thirty-one days after the employee becomes eligible for PEBB benefits;
- Included an employee may enroll in supplemental accidental death and dismemberment insurance with the contracted vendor at any time without evidence of insurability;
- Clarified enrollment if a newly eligible employee's employing agency or the health care authority's contracted vendor does not receive elections within thirty-one days;
- Clarified rules related to an employee regaining eligibility for the employer contribution toward PEBB benefits; and
- Clarified what are PEBB benefits and supplemental coverage throughout the WAC section.

Citation of Rules Affected by this Order: Amending WAC 182-08-197.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: PEBB Policy Resolution 2020-04.

Adopted under notice filed as WSR 20-13-074 on June 16, 2020.

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 0, Amended 1, Repealed 0.

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

Date Adopted: July 28, 2020.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, 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 provided the employee is eligible to waive PEBB medical and elects to waive as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency or contracted vendor. Their employing agency or contracted vendor must 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 supplemental life((~~, supplemental accidental death and dismemberment (AD&D),~~)) and supplemental long-term disability (LTD) insurance up to the guaranteed issue coverage amount 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 supplemental life((~~, supplemental AD&D,~~)) and supplemental LTD insurance over the guaranteed issue coverage amount at any time during the calendar year by submitting the required form to the contracted vendor for approval. An employee may enroll in supplemental accidental death and dismemberment (AD&D) insurance at anytime during the calendar year without evidence of insurability by submitting the required form to the contracted vendor.

(ii) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116), the employee will automatically enroll in the premium payment plan upon enrollment in PEBB medical allowing medical premiums 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 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 ((~~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;~~)) A medical plan determined by the health care authority (HCA);

(ii) ((~~Uniform Dental Plan;~~)) A dental plan determined by the HCA;

(iii) Basic life insurance;

(iv) Basic AD&D insurance;

(v) Basic ((~~long-term disability~~)) LTD insurance;

(vi) Dependents will not be enrolled; and

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

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

(3) When an employee regains eligibility for the employer contribution toward PEBB ((~~insurance coverage~~)) benefits, including following a period of leave ((~~(~~))described in WAC 182-12-133(1) ((~~and~~)), or after being between periods of leave as described in WAC 182-12-142 (1) and (2)((~~)~~)), or 182-12-131 (3)(e), PEBB medical and dental begin on the first day of the month the employee is in pay status eight or more hours.

(a) ((~~The~~)) An 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, 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)~~)) (a)(i) and (b) of this ((~~section~~)) subsection:

(i) An employee who self-paid for supplemental life insurance or supplemental AD&D coverage after losing eligibility will ((~~have~~)) maintain 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~~)) upon return;

(ii) An employee who was eligible to continue supplemental life or supplemental AD&D but discontinued that ((~~PEBB insurance~~)) supplemental 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 supplemental LTD insurance but discontinued that ((~~PEBB insurance~~)) supplemental coverage must submit evidence of insurability for 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 supplemental LTD insurance elections. Their 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 supplemental LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue 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, the employee's enrollment ((~~in PEBB insurance coverage~~)) for those elections not received will be as described in subsection (1)(b)(i) through ((~~(iv) and (vi)~~)) (vii) of this section, except as described in (a)(i) and (b) of this subsection.

(d) If an employee is eligible to participate in the salary reduction plan (see WAC 182-12-116) the employee may enroll in the medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these ((~~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 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~~)) benefits elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB ((~~insurance coverage~~)) benefits 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~~)) benefits elections also remain the same when an employee has a break in employment that does not interrupt their employer contribution toward PEBB ((~~insurance coverage~~)) benefits.

WSR 20-16-062
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2020-03—Filed July 28, 2020, 3:15 p.m., effective January 1, 2021]

Effective Date of Rule: January 1, 2021.

Purpose: The purpose is to amend some of the existing rules to support the public employees benefits board (PEBB) program.

1. Make Technical Amendments:

- Within the definitions sections of chapters 182-08, 182-12, and 182-16 WAC:
  - Amended the definition of "Calendar days" or "Days" to align with statute;
  - Made technical amendments to the definition "Health plan" by clarifying the board approves the health plan;
  - Amended the definition of "PEBB program" by adding a reference for eligible retired employees.
- Within the definitions sections of chapters 182-08 and 182-12 WAC:
  - Amended the definition of "Continuation coverage" to allow continuation of PEBB benefits instead of health plan coverage;
  - Amended the definition of "Defer" to allow deferral of PEBB insurance coverage instead of only health plans;
  - Amended the definition of "Waive" to clarify that only medical coverage may be waived;
- Within the definitions section of chapter 182-12 WAC:
  - Made a technical amendment to the definition of "Accidental death and dismemberment insurance";
  - Amended the definition of "SEBB" to remove the reference to the board;
  - Amended the definition of "SEBB insurance coverage" to include medical, dental, and vision coverage;
- Within the definitions section of chapter 182-16 WAC:
  - Added a definition of "Board."
  - Amended the definition of "Business days" to specify state legal holidays.
- Made global amendments in chapters 182-08, 182-12, and 182-16 WAC to update the use of health plan, PEBB insurance coverage, PEBB benefits, and specific benefits.
- Amended WAC 182-08-180 to clarify premium payments may be made to the contracted vendor in addition to the health care authority (HCA). Clarified notification regarding delinquent monthly premiums for a medicare advantage or medicare advantage-prescription drug plan. Amended WAC 182-08-180 to no longer allow insurance coverage to be terminated for nonpayment when an employee is on FMLA.
- Amended WAC 182-08-185 to update internal references and clarified that the spousal surcharge is based on enrollment in PEBB medical coverage.
- Amended WAC 182-08-187 to clarify that errors are related to PEBB benefits enrollment instead of insurance enrollment, updated vendors to the defined term contracted vendor. Clarified that refunds could be part of recourse. Also updated internal references, removed a note regarding notice requirements, added a WAC reference regarding supplemental LTD insurance during the period of leave, and made minor changes for readability.
- Amended WAC 182-08-187 and 182-12-113 because of the requirement for employees [to] be given at least ten days to make elections.
- Amended WAC 182-08-190 to clarify that the employer contribution goes towards PEBB benefits and includes enrolled dependents.
- Amended WAC 182-08-191 to provide technical corrections about addressing updates for appellants.
- Amended WAC 182-08-196 to reference high deductible health plans instead of consumer directed health plans and added clarity about timelines for electing a new medicare advantage plan.
- Amended WAC 182-08-198 to clarify that gaining initial eligibility or regaining eligibility does not create a special open enrollment. Added language about medicare advantage or medicare advantage-prescription drug plans. Clarified health plans start dates for extended and disabled dependents. Added clarity about changing medical plans when the subscriber is not eligible for a health savings account and that subscribers may not change their medical plan if it conflicts with the cafeteria plan.
- Amended WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-250 from entitlement to enrollment in medicare, medicaid, or children's health insurance program (CHIP).
- Amended WAC 182-08-235, 182-08-245, 182-12-111, and 182-12-146 to allow school board members to contract with the PEBB program for PEBB insurance coverage, and to outline the eligibility, procedural requirements, and continuation coverage options available.
- Amended WAC 182-08-245 to update information regarding employer groups or board members of school districts and educational service districts that must be submitted to the PEBB program.
- Amended WAC 182-12-111 to add board members of Washington state school districts and educational service districts eligibility and application process.
- Amended WAC 182-12-114 to clarify how governor declared emergencies impact eligibility. Added information about when benefits under the salary reduction plan, supplemental LTD, supplemental AD&D, and supplemental life begin.
- Amended WAC 182-12-123 to clarify employees may only have one enrollment in medical and dental. Amended WAC 182-12-123 and 182-12-250 to update the term "PEBB health plan" to "PEBB retiree insurance coverage" when speaking about deferring.
- Amended WAC 182-12-128 to clarify when medical coverage will begin for the newly born child, provide clarification on returning from waive status following medicaid or CHIP, newly adopted child, spouse, or state registered domestic partner and make minor technical corrections.

- Amended WAC 182-12-133 and 182-12-142 to clarify continuation coverage options for life and AD&D insurance.
- Amended WAC 182-12-138 to clarify and add details about the Paid Family and Medical Leave Program (PFML) and removed language to no longer allow insurance coverage to be terminated for non-payment when an employee is on FMLA or PFML.
- Amended WAC 182-12-146 to clarify, add details, and update references clarifying that state registered domestic partners and their children and a board member may have COBRA coverage on the same terms as a spouse or other eligible dependents.
- Amended WAC 182-12-148 to add a "court" as an entity to review a dismissal action, specify coverage "terminates" rather than "ends", and specifying employees "may enroll in" supplemental coverage rather than having coverage "restored" if retroactive premiums are not received.
- Amended WAC 182-12-207 to provide clarity that PEBB retiree insurance can be terminated for misconduct.
- Amended WAC 182-12-209 to clarify the retiree term life enrollment and deferral process.
- Amended WAC 182-12-250 to clarify medicare eligibility, added more information about enrollment in medicare advantage or medicare advantage-prescription drug plans and clarified enrollment requirements for those who are eligible for medicare Parts A and B.
- Amended WAC 182-12-260 to specify that dependent verification applies to PEBB health plan enrollment, clarified dependent verification for a dependent child with a disability beginning at age twenty-six, removed parents as an eligible dependent, added clarification regarding a dependent child with a disability process and clarified when dependents may be added.
- Amended WAC 182-12-262 to clarify when PEBB insurance coverage begins including supplemental dependent life and AD&D insurance, that a National Medical Support Notice allows a subscriber to add or remove dependents, and that supplemental dependent life and AD&D insurance may be elected or removed anytime. Clarified enrollment requirements regarding supplemental dependent life and AD&D insurance. Added information about applicable premium payments and premium surcharge payments to related medicare advantage and medicare advantage-prescription drug plans.
- Amended WAC 182-12-263 to clarify when a dependent already enrolled may be removed from health plan coverage.
- Amended WAC 182-12-270 to specify that medical and dental premiums and applicable premium surcharges must be made to HCA and premium surcharges are related to medical coverage and that state registered domestic partners and their children may have COBRA on the same terms as a spouse or other eligible dependents.
- Amended WAC 182-12-300 to clarify that you must be enrolled in a PEBB medical plan to receive the wellness incentive and made minor technical corrections.
- Amended WAC 182-16-058 with technical corrections.
- Amended WAC 182-16-066 to refer to "state agencies."
- Amended WAC 182-16-120 to make technical changes including specifying state legal holidays.
- Amended WAC 182-16-130 to specify orders instead of decisions.
- Amended WAC 182-16-2010 to correct the name of the salary reduction plan.
- Amended WAC 182-16-2020 to specify that requests for administrative review must be written and provided deadlines for PEBB appeals unit to receive requests for administrative review. Changes clarify what happens if an employee does not appeal a brief adjudicative proceeding.
- Amended WAC 182-16-2030 for readability.
- Amended WAC 182-16-2040 clarify the decision if a subscriber fails to request a brief adjudicative proceeding timely.
- Amended WAC 182-16-2050 to specify that request for review must be a written request, added language about requesting a brief adjudicative proceeding, and information about when orders are effective, and changed the word "decision" to order.
- Amended WAC 182-16-2060 to clarify the decision if a brief adjudicative proceeding is not requested timely.
- Amended WAC 182-16-2070 to specify review of employing agency decisions.
- Amended WAC 182-16-2085 and 182-16-2160 to remove the word "motion" for readability.
- Amended WAC 182-16-2090 to spell out PEBB and to make other changes for readability.
- Amended WAC 182-16-2100 to specify that the initial order becomes the authority's final order and changes for readability.
- Amended WAC 182-16-2110 to make technical corrections.
- Amended WAC 182-16-2110, 182-16-2150, and 182-16-3170 by streamlining language to improve readability.
- Amended WAC 182-16-2120 updated a reference and changes for readability.
- Amended WAC 182-16-3000 and 182-16-3120 by updating references.
- Amended WAC 182-16-3030 may allow argument only to preserve the record for judicial review.
- Amended WAC 182-16-3100 to specify rescheduling the formal administrative hearing and removed the requirement to immediately telephone all other parties in the event of a continuance.
- Amended WAC 182-16-3130 to spell out HCA the first time it is used.
- Amended WAC 182-16-3140 to update "good cause" requirements, update references, and make a minor change for readability.
- Amended WAC 182-16-3180 clarified what new information may be introduced.

- Amended WAC 182-16-3190 by replacing "dispose of" with "decide."

2. Amend rules to improve administration of the PEBB program:

- Amended WAC 182-08-180 to add the acronym AD&D after the accidental death and dismemberment insurance.
- Amended WAC 182-08-190 to remove repetitive language.
- Amended WAC 182-08-199 by making corrections to use the correct acronyms.
- Amended WAC 182-12-111 by making corrections to the format and using the correct acronyms.

Citation of Rules Affected by this Order: Amending WAC 182-08-015, 182-08-180, 182-08-185, 182-08-187, 182-08-190, 182-08-191, 182-08-196, 182-08-198, 182-08-199, 182-08-235, 182-08-245, 182-12-109, 182-12-111, 182-12-113, 182-12-114, 182-12-123, 182-12-128, 182-12-129, 182-12-131, 182-12-133, 182-12-138, 182-12-141, 182-12-142, 182-12-146, 182-12-148, 182-12-207, 182-12-208, 182-12-209, 182-12-250, 182-12-260, 182-12-262, 182-12-263, 182-12-270, 182-12-300, 182-16-020, 182-16-058, 182-16-066, 182-16-120, 182-16-130, 182-16-2010, 182-16-2020, 182-16-2030, 182-16-2040, 182-16-2050, 182-16-2060, 182-16-2070, 182-16-2085, 182-16-2090, 182-16-2100, 182-16-2110, 182-16-2120, 182-16-2150, 182-16-2160, 182-16-3000, 182-16-3030, 182-16-3100, 182-16-3120, 182-16-3130, 182-16-3140, 182-16-3170, 182-16-3180, and 182-16-3190.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 20-13-073 on June 16, 2020.

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 0, Amended 62, 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 62, Repealed 0.

Date Adopted: July 28, 2020.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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, 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.

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

"Calendar days" or "days" means all days including Saturdays, Sundays, and all ((~~legal~~)) state legal 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~~)) PEBB benefits available to enrollees 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 the public employees benefits 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~~)) insurance coverage 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 employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under 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; (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); (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 HCA by a state agency or employer group 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, 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 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 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, 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 ((~~PEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of $50 or ten percent of

the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

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

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

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

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life 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" 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.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state 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 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, and 182-12-211), 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 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 public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, 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. 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, 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.

"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 an eligible employee affirmatively declining enrollment in ((~~a~~)) PEBB ((~~health~~)) medical plan because the employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 (4) or (5).

(1) **Premium payments.** 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) or the contracted vendor 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 (AD&D) 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 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 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 or contacted vendor. 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.

Exception: For a subscriber enrolled in a medicare advantage or a medicare advantage-prescription drug plan a notice will be sent to them notifying them that they are delinquent on their monthly premiums and that the enrollment will be terminated prospectively to the end of the month after the notice is sent.

(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 or contracted vendor 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 or contracted vendor 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, and provides clear and convincing evidence of extraordinary circumstances, such that 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 PEBB 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 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~~)) subsection.

(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 website 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 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 as described in WAC 182-12-262. The subscriber must complete the required form to enroll their spouse or state registered domestic partner, 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) 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

(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 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 if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB ((~~coverage~~)) medical.

(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 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 19-17-073, filed 8/20/19, effective 1/1/20)

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)~~)) (5) 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~~)) benefits as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB ((~~insurance coverage~~)) benefits 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;

(e) Enrolling an employee or their dependent 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 (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (4) of this section, and provide recourse as described in subsection (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.~~))

(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 (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) Supplemental life, supplemental AD&D, and 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~~)) on 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) Supplemental life, supplemental AD&D, and 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 supplemental LTD insurance during the period of leave as described in WAC 182-12-133, 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 supplemental life insurance, supplemental AD&D insurance, and 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~~)) benefits will be terminated prospectively effective as of the last day of the month.

(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 starting the date PEBB ((~~insurance coverage~~)) benefits begins as described in subsections (3) and (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 the months ((~~following notification of a new enrollment period~~)) after the employee was notified.

(b) When an employing agency fails to correctly enroll the amount of 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 a premium refund((~~s are~~)) is due to the employee, the supplemental LTD insurance contracted 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 refund((~~s~~)).

(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.

(5) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is estab-

lished 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 (3)(b), (c) and (d) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB ((~~insurance coverage~~)) benefits within the following parameters:

(i) Retroactive enrollment in a PEBB ((~~health plan~~)) insurance coverage;

(ii) Reimbursement of claims paid;

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

(iv) Reimbursement of amounts paid by the employee for the premium surcharges;

(v) Other legal remedy received or offered; or

(((~~v~~))) (vi) 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 that participate in the public employees benefits board (PEBB) program under contract with the health care authority (HCA) must pay the employer contributions to the ((~~health care authority (~~))HCA((~~)~~)) for PEBB ((~~insurance coverage~~)) for all eligible employees and their enrolled 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~~)) benefits 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 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.

(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.

(7) The terms of payment to HCA for employer groups shall be stipulated under contract with the HCA.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 public employees benefits board (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~~)) In the event of an appeal, appellants must update their address as required in WAC 182-16-055.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 must elect a new health plan when their previously selected health plan becomes unavailable due to a change in contracting service area 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.

(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 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.

(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 elect a new health plan within the required time period as required in (a) or (b) of this subsection will be enrolled in a health plan designated by the director or designee.

(2) A subscriber must elect a new health plan when their previously selected health 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.

Exception: The required forms electing a new medicare advantage plan must be received no later than two months 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~~)) high deductible health plan (((~~CDHP~~))) (HDHP) with a health savings account (HSA), ((~~who~~)) and 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)(e) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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

(1) **During the annual open enrollment:** A subscriber may change health plans during the public employees benefits board (PEBB) annual open enrollment period. A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. Any other subscriber 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 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 as described in WAC 182-12-114 or regaining eligibility for PEBB benefits as described in WAC 182-08-197. The change in enrollment must be allowable under Internal Revenue Code 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 disenroll from a medicare advantage plan or medicare advantage-prescription drug plan, the change in enrollment must be allowable under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c). To make a health plan change, 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. Any other subscriber submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber 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 or medicare advantage-prescription drug plan, they may disenroll during a special enrollment period as allowed under Title 42 C.F.R. The new ((~~health~~)) medical 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 support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or eligibility certification. 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;

Note: 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~~)) enrolls in 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 CHIP;

(i) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in 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 advantage-prescription drug or a Part D plan. If the subscriber's current ((~~health~~)) medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's ((~~entitlement to~~)) enrollment in medicare, the subscriber must select a new ((~~health~~)) medical plan as described in WAC 182-08-196(2).

(i) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage 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;

(ii) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has seven months to enroll in a medicare advantage or medicare advantage-prescription drug plan that begins three months before they or their dependent first enrolled in both medicare Part A and Part B and ends three months after the month of medicare eligibility. A subscriber may also enroll themselves or their dependent in a medicare advantage or medicare advantage-prescription drug plan before their last day of the medicare Part B initial enrollment period. The forms must be received by the PEBB program no later than the last day of the month prior to the month the subscriber or the subscriber's dependent enrolls in the medicare advantage or medicare advantage-prescription drug plan.

(j) Subscriber or a subscriber's dependent's current ((~~health~~)) medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority 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. 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;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period; or

(v) Treatment for a high-risk pregnancy.

(3) If the employee is having premiums taken from payroll on a pretax basis, a ((~~health~~)) medical 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 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 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 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 employee;

• Birth, adoption, or when the 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;

Note: 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.

(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~~)) enrolls in 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~~)) medical plan coverage from medicaid or CHIP;

(xii) Employee or an employee's dependent ((~~becomes entitled to~~)) enrolls in 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~~)) medical 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. 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;

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period; or

• 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 medical 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 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 employee;

• Birth, adoption, or when the 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~~)) enrolls in 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~~)) enrolls in coverage under medicare.

(c) **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 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-235 Employer group and board of directors for school districts and educational service districts application process. This section applies to employer groups as defined in WAC 182-08-015 and board members of school districts and educational service districts. An employer group or board member of a school district or an educational service district may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups and board members of school districts and educational service districts with less than five hundred employees must apply at least sixty days before the requested coverage effective date. Employer groups 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 with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups

must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) Board members of school districts and educational service districts and educational service districts applying for ((~~its~~)) their nonrepresented employees are required to provide the documents described in subsection((~~s~~)) (2)(a) through (c) of this section;

Exception: 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 board members of school district or educational service district tax ID number (TIN); and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages. Educational service districts applying for its nonrepresented employees must purchase medical, dental, life, and long-term disability insurance. Board members of school districts or educational service districts must provide a statement of whether the group is applying to obtain medical, dental, and life 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~~)) Birth sex;

(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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-08-245 Employer group and board members of school districts and educational service districts participation requirements. This section applies to an employer group as defined in WAC 182-08-015 or board members of school districts or educational service districts 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 board members of school districts or educational service districts 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 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 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 educational service districts 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. 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 described in (a) of this subsection and board members of school districts and educational service districts 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 board member of school districts and educational service districts want((s)) to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(5) The employer group or board members of school districts and educational service districts must maintain participation in PEBB insurance coverage for at least one full year. An employer group or board members of school districts and educational service districts 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 member of school districts and educational service districts 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 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 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 19-17-073, filed 8/20/19, effective 1/1/20)

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~~)) 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, 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, Sundays, and all ((~~legal~~)) state legal 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~~)) PEBB benefits available to enrollees 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 the public employees benefits 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~~)) PEBB insurance coverage 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 employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under 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; (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); (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 HCA by a state agency or employer group 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, 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 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 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, 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 ((~~PEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

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

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

"Life insurance" means basic life insurance paid for by the employing agency, as well as supplemental life 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" 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.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state 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 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 insur-

ance, 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, and 182-12-211), 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 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 public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, 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 the school employees benefits board ((~~established in RCW 41.05.740~~)).

"SEBB insurance coverage" means any ((~~health plan~~)) medical, dental, vision, 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 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. 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, 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.

"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 an eligible employee affirmatively declining enrollment in ((~~a PEBB health plan~~)) PEBB medical because the employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 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 participate through a contract with the authority as described in WAC 182-08-245.

(3) **Washington state educational service districts.** In addition to subsection (2) of this section, the following applies to Washington state educational service districts 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 educational service district.

(b) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505.030.

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

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

(b) 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.

(i) 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((~~.~~)); or

((~~(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)~~)) (ii) 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 Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage as described in WAC 182-12-146(5).

((~~(v)~~)) (iii) 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~~)) medical and dental while enrolled in that program.

(c) ((~~School~~)) Board members ((~~or students~~)) of Washington state school districts and educational service districts eligible to participate under RCW 28A.400.350 may participate in PEBB ((~~insurance coverage~~)) medical, dental, basic

life insurance, basic accidental death and dismemberment (AD&D) insurance, supplemental life insurance, and supplemental AD&D insurance as long as they remain eligible under that section. The board of directors must apply through the process described in WAC 182-08-235 and participate through a contract with the HCA as described in WAC 182-08-245. Dependents of board members are eligible as described in WAC 182-12-260.

(i) Upon contract with the HCA, eligible board members may individually decide to enroll in PEBB insurance coverage each plan year. If they elect not to enroll, they may only enroll at the following times:

• During the annual open enrollment; or

• Following loss of other medical insurance coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA).

(ii) Board members who no longer hold a position become ineligible to participate in PEBB insurance coverage as described in (c) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical, PEBB dental, or both on a self-pay basis under COBRA coverage as described in WAC 182-12-146(6).

(iii) Board members are not eligible for PEBB retiree insurance coverage.

(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 19-17-073, filed 8/20/19, effective 1/1/20)

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

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

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

(c) Carry out corrective action and pay any penalties imposed by the authority and established by the board when the state agency's eligibility determinations fail to comply with the criteria under these rules.

(2) All state agencies must determine employee eligibility for PEBB benefits and 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 PEBB benefits upon employment. The written ((~~communication~~)) notice 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. An employee eligible for PEBB benefits must have no less than ten calendar days after the date of notice to elect coverage;

(d) Routinely monitor all employees' eligible work hours to establish eligibility and maintain the employer contribution toward PEBB 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 PEBB benefits and the employer contribution whenever there is a change in work pattern((~~s~~)) such that the employee's eligibility status changes. Whenever this occurs, state agencies must inform the employee of the right to appeal eligibility and enrollment decisions. An employee eligible for PEBB benefits must have no less than ten calendar days after the date of notice to elect coverage.

(3) State agencies must determine employee's dependents eligibility for PEBB ((~~benefits~~)) health plan coverage according to the criteria in WAC 182-12-260.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 (except governor-declared emergencies) that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Any hours worked in direct response to a governor-declared emergency are not excludable and must be included in determining eligibility. In order

to include excluded hours in determining eligibility, employing agencies must request and receive 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~~)) benefits 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~~)) benefits. 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~~)) benefits as described in WAC 182-12-131(1).

(d) **When PEBB ((~~insurance coverage~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, ((~~and~~)) basic long-term disability (LTD) insurance, and if eligible, benefits under the salary reduction plan 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. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(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~~)) benefits. 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~~)) benefits as described in WAC 182-12-131(1).

(d) **When PEBB ((~~insurance coverage~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan 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. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(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~~)) benefits 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~~)) benefits begin((~~s~~)).**

(i) Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan 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. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(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, and if eligible, benefits under the salary reduction plan 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. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(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~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan 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. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(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~~)) benefits begin((~~s~~)).** Medical, dental, basic life insurance, basic AD&D insurance, ((~~and~~)) basic LTD insurance, and if eligible, benefits under the salary reduction plan 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. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-123 Is dual enrollment in public employees benefits board (PEBB) prohibited? Public employees benefits board (PEBB) ((~~health plan~~)) medical and dental 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~~)) medical and dental 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~~)) medical 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~~)) PEBB medical or dental 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~~)) medical 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 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~~)) medical and dental 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~~)) medical 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~~)) under both subscribers but is limited to a single enrollment in PEBB medical and a single enrollment in PEBB dental.

(5) When an employee is eligible for the employer contribution toward((~~s PEBB insurance coverage~~)) PEBB benefits 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 must notify their other employing agency no later than sixty days from the date PEBB ((~~coverage~~)) benefits end((~~s~~)) 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 under one employing agency to another employing agency without a break in PEBB ((~~insurance coverage~~)) benefits for one month or more, as described in (b) of this subsection.

(6) A retiree who defers enrollment in ((~~a PEBB health plan~~)) PEBB retiree insurance coverage as described in WAC 182-12-200 by enrolling as an eligible dependent in a health plan sponsored by PEBB, a Washington state educational service district, or 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 enrollment 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 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 PEBB 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 may not enroll dependents 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 for the employee will begin ((~~for an employee~~)) on the first day of the month in which the event occurs ((~~(see WAC 182-12-262 for the~~)). PEBB medical ((~~effective date of a~~)) for the newly born child, newly adopted child, spouse, or state registered domestic partner((~~)~~)) will begin as described in WAC 182-12-262 (3)(a)(iv).

(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 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;

Note: 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 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~~)) enrolls in 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;

Note: An employee may only return from having waived PEBB medical for the events described in (h) of this subsection. An employee may not waive their PEBB medical for the events described in (h) of this subsection.

(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)~~)) 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 182-12-129 What happens when an employee moves from an eligible to an otherwise ineligible position or job due to a layoff? This section applies to employees employed by state agencies (as defined in this chapter), including benefits-eligible seasonal employees, and is intended to address situations where an employee moves from one position or job to another due to a layoff, as described in WAC 182-12-109. This section does not apply to employees with an anticipated end date.

If an employee moves from an eligible to an otherwise ineligible position due to layoff, the employee may retain their eligibility for the employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits for each month that the employee is in pay status for at least eight hours. To maintain eligibility using this section the employee must:

• Be hired into a position with a state agency within twenty-four months of the original eligible position ending; and

• Upon hire, notify the employing state agency that they are potentially eligible to use this section.

This section ceases to apply if the employee is employed in a position eligible for PEBB benefits under WAC 182-12-114 within twenty-four months of leaving the original position.

After the twenty-fourth month, the employee must reestablish eligibility as described in WAC 182-12-114.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits? The employer contribution toward public employees benefits board (PEBB) ((~~insurance coverage~~)) benefits 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~~)) benefits.

(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~~)) benefits for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) 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~~)) benefits.

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester PEBB ((~~insurance coverage~~)) benefits 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~~)) benefits end((~~s~~)) 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~~)) benefits. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of 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~~)) benefits 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~~)) benefits 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 subsections (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~~)) benefits end((~~s~~)) 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~~)) benefits, 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 benefits due to an event described in (b)(i) through (vi) of this subsection may continue ((~~PEBB benefits~~)) coverage 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((~~,~~)) or dental, and may also continue life insurance((~~,~~)) and accidental death and dismemberment (AD&D) insurance((~~; however, only~~)). If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance. 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 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; 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 are due 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 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 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 19-17-073, filed 8/20/19, effective 1/1/20)

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~~)) benefits in accordance with the federal FMLA ((~~or RCW 50A.04.245~~)). The employee may also continue current supplemental life, supplemental accidental death and dismemberment (AD&D), and 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 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 were paid.~~))

(2) An employee on approved leave under the paid family and medical leave program under chapter 50A.05 RCW may continue to receive the employer contribution toward PEBB benefits in accordance with RCW 50A.35.020. The employee may also continue current supplemental life, supplemental AD&D, and supplemental LTD insurance. The employment security department is responsible for determining if the employee is eligible for the paid family and medical leave program.

(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 employing agency.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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~~)) benefits 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 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 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 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~~)) benefits 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 19-17-073, filed 8/20/19, effective 1/1/20)

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((~~,~~)) or dental, and may also continue life insurance((~~,~~)) and accidental death and dismemberment (AD&D) insurance by self-paying the premium and applicable premium surcharges set by the health care author-

ity (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance:

(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 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 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 were paid as described in WAC 182-08-180 (1)(c).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical((,)) or dental, and may also continue 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. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. Employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance:

(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 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 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 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-146 When is an enrollee eligible to continue public employees benefits board (PEBB) ((~~health plan coverage~~)) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) 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 PEBB 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 PEBB medical, dental, or both for the remaining difference in months.

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

(4) A retiree or a dependent of a retiree, who is no longer eligible as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue PEBB medical, dental, or both.

(5) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in 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) A board member who no longer qualifies as described in WAC 182-12-111 (5)(c) may continue enrollment in PEBB medical, dental, or both for the maximum number of months allowed under COBRA as described in this section.

(7) An enrollee may continue PEBB ((~~health plan coverage~~)) medical, dental, or both 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)~~)) (8) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB medical, dental, or both on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(9) 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting the hearing outcome 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; or

(d) A court.

(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 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 were paid as described in WAC 182-08-180 (1)(c).

(3) If the dismissal is upheld, all PEBB insurance coverage will ((~~end~~)) terminate 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 PEBB 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. In the alternative, at the request of the employee, HCA may deduct the employee's contribution amount for PEBB ((~~insurance coverage~~)) benefits from the refund of premiums and applicable premium surcharges self-paid by the employee during the appeal period.

(b) All supplemental life, supplemental accidental death and dismemberment, and 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 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~~)) enroll in such supplemental coverage.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 retiree 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 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage? The following provisions apply to a subscriber and their dependents enrolled under public employees benefits board (PEBB) retiree insurance coverage:

(1) A subscriber enrolling in PEBB dental must meet procedural and eligibility requirements under one of the following: WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, 182-12-250, 182-12-262, or 182-12-265. The subscriber's dependents must meet eligibility criteria as described in WAC 182-12-250 or 182-12-260.

(2) A subscriber and their dependents must be enrolled in PEBB medical to enroll in PEBB dental. If a subscriber elects to enroll dependents in PEBB dental coverage, the dependents must be enrolled in the same PEBB dental plan as the subscriber.

(3) A subscriber enrolling in PEBB dental must stay enrolled for at least two years before dental can be dropped unless they defer or terminate ((~~medical and dental~~)) PEBB retiree insurance coverage as described in WAC 182-12-200 or 182-12-205, or drop((~~s~~)) dental as described in subsection (4) of this section.

(4) A subscriber enrolled in PEBB dental who becomes eligible for, and enrolls in, employer-based group dental as an employee or the dependent of an employee, or such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), or continuation coverage may drop PEBB dental, before completing the two-year enrollment requirement. Coverage will end on the last day of the month in which the required form is received by the PEBB program. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(a) A subscriber may enroll, terminate, or change their election in PEBB dental during the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. The change in PEBB dental begins January 1st of the following year.

(b) A subscriber may enroll in PEBB dental after their employer-based group dental or such coverage under COBRA coverage or continuation coverage ends. The required form must be received by the PEBB program no later than sixty days after such coverage ends. PEBB dental begins the first day of the month after the employer-based group dental coverage or continuation coverage under COBRA ends.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 basic 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 basic 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 basic life insurance; or

(b) To stop self-paying retiree term life insurance premiums during the period they are eligible for PEBB or SEBB employee basic life insurance and ((~~reelect~~)) elect retiree term life insurance when ((~~they are no longer eligible for the employer contribution toward~~)) PEBB or SEBB employee basic life insurance ends.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage.

(1) This section applies to the surviving spouse, the surviving state registered domestic partner, and dependent children of emergency service personnel "killed in the line of duty" as determined by the Washington state department of labor and industries.

(2) "Emergency service personnel" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010.

(3) "Surviving spouse, state registered domestic partner, and dependent children" means:

(a) A lawful spouse;

(b) An ex-spouse as defined in RCW 41.26.162;

(c) A state registered domestic partner as defined in RCW 26.60.020(1); and

(d) Children. The term "children" includes children of the emergency service worker up to age twenty-six. Children with disabilities as defined in RCW 41.26.030(6) are eligible at any age. "Children" is defined as:

(i) Biological children (including the emergency service worker's posthumous children);

(ii) Stepchildren or children of a state registered domestic partner;

(iii) Legally adopted children;

(iv) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(v) Children specified in a court order or divorce decree; or

(vi) Children as defined in RCW 26.26A.100.

(4) Surviving spouses, state registered domestic partners, and children who are ((~~entitled to~~)) eligible for medicare must enroll in both Parts A and B of medicare.

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(5) The survivor (or agent acting on their behalf) must submit the required forms to the PEBB program to either enroll or defer enrollment in PEBB retiree insurance coverage as described in subsection (7) of this section. The forms must be received by the PEBB program no later than one hundred eighty days after the later of:

(a) The death of the emergency service worker;

(b) The date on the letter from the department of retirement systems or the board for volunteer firefighters and reserve officers that informs the survivor that they are determined to be an eligible survivor;

(c) The last day the surviving spouse, state registered domestic partner, or child was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving spouse, state registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

(6) Survivors who do not choose to defer enrollment in PEBB retiree insurance coverage may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose required forms are received by the PEBB program no later than September 1, 2006;

(b) The first of the month that is not earlier than sixty days before the date that the PEBB program receives the required forms (for example, if the PEBB program receives the required forms on August 29th, the survivor may request health plan enrollment to begin on July 1st); or

(c) The first of the month after the date that the PEBB program receives the required forms.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

For surviving spouses, state registered domestic partners, and children who enroll, monthly health plan premiums and applicable premium surcharges must be paid by the survivor as described in WAC 182-08-180 (1)(c) except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

(7) Survivors must choose one of the following two options to maintain eligibility for PEBB retiree insurance coverage:

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled for at least two years before dental can be dropped, unless they defer ((~~medical and dental~~)) PEBB retiree insurance coverage as described in WAC 182-12-205, or drop dental as described in WAC 182-12-208(4).

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in ((~~a PEBB health plan~~)) PEBB retiree insurance coverage if continuously enrolled in qualifying coverage as described in WAC 182-12-205(3).

(ii) Survivors may enroll in a PEBB health plan as described in WAC 182-12-205(6) when they lose other cov-

erage. Survivors must provide evidence that they were continuously enrolled in one or more qualifying coverages as described in WAC 182-12-205 (3)(a) through (e) when enrolling in a PEBB health plan. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(iii) PEBB health plan enrollment and premiums will begin the first day of the month following the day that the other coverage ended for eligible spouses and children who enroll.

(8) Survivors may change their health plan during the annual open enrollment. In addition to the annual open enrollment, survivors may change health plans as described in WAC 182-08-198.

(9) Survivors will lose their right to enroll in PEBB retiree insurance coverage if they:

(a) Do not apply to enroll or defer ((~~PEBB health plan~~)) enrollment within the timelines as described in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in other qualifying coverage during the deferral period, as described in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-260 Who are eligible dependents? To be enrolled in PEBB ((~~benefits~~)) health plan coverage, 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~~)) coverage if the PEBB program is unable to verify a dependent's eligibility. ((~~The PEBB program will not enroll dependents into PEBB benefits~~)) A dependent will not be enrolled in PEBB health plan coverage if the PEBB program or the employing agency is unable to verify ((~~a~~)) the dependent's eligibility within the PEBB program enrollment timelines.

The subscriber must provide notice, in writing, when their dependent is not eligible under this section as described in WAC 182-12-262 (2)(a).

The following are eligible as dependents:

(1) Legal spouse. A former spouse is not an eligible dependent 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. A former state registered domestic partner is not an eligible dependent 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 (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 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 adoption of the child;

(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;

(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;

(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

(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 notify the PEBB program, in writing, 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 sub-

section 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~~)). Verification will require renewed proof of disability and dependence 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) ((~~benefits~~)) health plan coverage and the effective date of supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance.** 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 PEBB benefits. If eligibility is verified ((~~and the dependent is enrolled,~~)) the dependent's effective date will be as follows:

(i) PEBB health plan coverage will be the same as the subscriber's effective date((~~, except if the subscriber enrolls a newborn child in 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~~));

(ii) Supplemental dependent life or AD&D insurance, if elected, will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(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;

(d) **When a National Medical Support Notice (NMSN)** requires a subscriber to cover a dependent child as described in WAC 182-12-263; or

(e) **Any time during the calendar year for supplemental dependent life insurance or AD&D insurance** by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

(2) **Removing dependents from a subscriber's PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance.**

(a) **A dependent's eligibility for enrollment in PEBB health plan coverage or supplemental dependent life insurance or AD&D insurance ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Subscribers must 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 PEBB 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. Consequences for not submitting notice within the required sixty days include, but are not limited to:

(i) The dependent may lose eligibility to continue ((~~health plan coverage~~)) PEBB medical or dental 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 from PEBB health plan coverage the last day of December; ((~~or~~))

(ii) During a special open enrollment as described in subsections (3) and (4)(f) of this section;

(iii) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in PEBB coverage, and that health plan coverage is in fact provided as described in WAC 182-12-263(2); or

(iv) Any time during the calendar year from supplemental dependent life or AD&D insurance by submitting the required form to the contracted vendor.

(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 PEBB continuation coverage 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~~)) health plan 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~~)) health plan coverage prospectively. PEBB ((~~insurance~~)) health plan 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, PEBB health plan coverage will end on the last day of the previous month. PEBB continuation coverage enrollees may remove supplemental dependent life or AD&D insurance any time during the calendar year by submitting the required form to the contracted vendor.

(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 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. To disenroll from a medicare advantage or medicare advantage-prescription drug plan, the change in enrollment must be allowable under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c).

(i) PEBB ((~~benefits~~)) health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

(ii) ((~~Enrollment of~~)) PEBB health plan coverage for an extended dependent or a dependent with a disability will ((~~be~~)) begin 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 PEBB 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, PEBB ((~~benefits~~)) health plan coverage will begin or end as follows:

• For the newly born child, PEBB ((~~benefits~~)) health plan coverage will begin the date of birth;

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

• For a spouse or state registered domestic partner of a subscriber, PEBB ((~~benefits~~)) health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from PEBB 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 supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective.~~))

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

((~~(b)~~)) (i) Subscriber acquires a new dependent due to:

((~~(i)~~)) • Marriage or registering 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)~~)) (ii) 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)~~)) (iii) 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)~~)) (iv) 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;

Note: As used in ((~~(e)~~)) (iv) 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)~~)) (v) 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)~~)) (vi) 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)~~)) (vii) 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)~~)) (viii) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in 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)~~)) (ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP.

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** For PEBB health plan coverage, an employee must submit the required forms to their employing

agency, a subscriber 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. An employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval within the required time frames.

(a) If a subscriber wants to enroll their eligible dependents in PEBB health plan coverage when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms and submit them within the 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. If an employee enrolls a dependent in supplemental life insurance or AD&D insurance, the required form must be submitted within the required time frame described in WAC 182-08-197 or 182-08-187.

(b) If a subscriber wants to enroll eligible dependents in PEBB health plan coverage 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. An employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. An employee may enroll a dependent in supplemental life insurance up to the guaranteed issue coverage amount without evidence of insurability if the required form is submitted to the contracted vendor as required. Evidence of insurability will be required for supplemental dependent life insurance over the guaranteed issue coverage amount. Evidence of insurability is not required for supplemental AD&D insurance.

(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 in PEBB health plan coverage, 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 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. An employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage can become effective.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability in PEBB health plan coverage, 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) of this subsection. 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 health plan coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status in PEBB health plan coverage 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.

Exception: If the subscriber wants to change a dependent's enrollment or disenrollment in a medicare advantage or medicare advantage-prescription drug plan, the required forms must be received during a special enrollment period as allowed under 42 C.F.R. Sec. 422.62(b) and 42 C.F.R. Sec. 423.38(c).

(g) An employee may enroll a dependent in supplemental life insurance or AD&D insurance at any time during the calendar year by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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:

(a) The subscriber may enroll their dependent child and request changes to their health plan coverage as described under subsection (c) of this section. Employees submit the required forms to their employing agency. Subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the public employees benefits board (PEBB) program.

(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 (c) of this subsection upon request of:

(i) The child's other parent; or

(ii) Child support enforcement program.

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

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

(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;

(iii) The subscriber's selected health plan will be changed if directed by the NMSN;

(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; 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.

(d) Changes to health plan coverage or enrollment as described in (c)(i) through (iii) of this 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 (c)(iv) of this 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.

(2) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in PEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's PEBB ((~~insurance~~)) health plan coverage prospectively.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 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. 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 insurance coverage. Following the 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 as they 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 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~~)) PEBB medical, dental, or both 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, 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) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB medical, dental, or both on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(4) 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The ((~~public employees benefits board (PEBB)~~)) board 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, 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 following deadline:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January through September, the deadline is November 30th; or

(b) For subscribers enrolling in PEBB medical with an effective date in October 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 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) A PEBB wellness incentive will be provided only if:

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

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

(c) Specific appropriations are provided for wellness incentives.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 who requests a brief adjudicative proceeding with the PEBB appeals unit about the action of the employing agency, the HCA, or its contracted vendor.

"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.

"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 state legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all ((~~legal~~)) state legal 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, 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 employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under 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 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; (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); (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, non-

represented 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, 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, 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 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 ((~~PEBB~~)) board 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" means basic life insurance paid for by the employing agency, as well as supplemental life 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" 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.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state 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 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, and 182-12-211), 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 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 public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, 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. 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, 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.

"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 182-16-058 Service or serve. (1) When the rules in this chapter or in other public employees benefits board (PEBB) program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives as described in this chapter. In this section, requirements for service or delivery by a party apply also when service is required by the presiding officer, review officer or officers, or hearing officer.

(2) Unless otherwise stated in applicable law, documents may be sent only as identified in this chapter to accomplish service. A party may serve someone by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail sent via the United States Postal Service or Washington state consolidated mail services;

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document with the presiding officer, review officer or officers, or hearing officer's office, or when required by law.

(4) Service is complete when:

(a) Personal service is made;

(b) Mail is properly stamped, addressed, and deposited in the United States Postal Service;

(c) Mail is properly addressed, and deposited in the Washington state consolidated mail services;

(d) Fax produces proof of transmission;

(e) A parcel is delivered to a commercial delivery service with charges prepaid; or

(f) A parcel is delivered to a legal messenger service with charges prepaid.

(5) A party may prove service by providing any of the following:

(a) A signed affidavit of mailing or certificate of ((~~mailing~~)) service;

(b) The certified mail receipt signed by the person who received the parcel;

(c) A signed receipt from the person who accepted the commercial delivery service or legal messenger service parcel;

(d) Proof of fax transmission.

(6) Service cannot be made by electronic mail unless mutually agreed to in advance and in writing by the parties.

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-16-3130.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and state 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 Friday and the party has twenty-one days to request a review, start counting the days with Saturday.)

(2) 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 ten days or less, intermediate Saturdays, Sundays and state legal holidays ((~~shall~~)) must 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-130 Index of significant decisions. (1) A final ((~~decision~~)) order 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) website. As decisions are indexed they will be available on the website.

(3) A final ((~~decision~~)) order 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~~)) order; or

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

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2010 Appealing a decision regarding public employees benefits board (PEBB) eligibility, enrollment, premium payments, premium surcharges, a 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 described in WAC 182-16-2020.

Note: Eligibility decisions address whether a subscriber or a subscriber's dependent is entitled to PEBB 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 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 enrollee aggrieved by a decision regarding the administration of ((~~a health plan~~)) PEBB medical and dental, 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2020 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 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 must render a written decision within thirty days of receiving the written request for administrative review. The written decision must be sent to the employee or employee's dependent who submitted the request for administrative review and must include a description of the appeal rights. The state agency 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 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. If a state agency fails to render a written decision within thirty days of receiving a written request for administrative review, the PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. 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 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 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~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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, or 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 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~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 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~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2050 How can an employee appeal a decision regarding the administration of benefits offered under the salary reduction plan? (1) Any employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the 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 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 must render a written decision within thirty days of receiving the written request for administrative review. The written decision must be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency 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. If a state agency fails to render a written decision within thirty days of receiving a written request for administrative review, the PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. 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 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~~)) order without further 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 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 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 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~~)) order without further action.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the 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 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~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 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~~)) order without further action.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2070 What should a written request for administrative review and a request for brief adjudicative proceeding contain? A written request for administrative review of the employing agency decision and a request for brief adjudicative proceeding should contain:

(1) The name and mailing address of the party requesting an administrative review or the brief adjudicative proceeding;

(2) The name and mailing address of the appealing party's representative, if any;

(3) Documentation, or reference to documentation, of decisions previously rendered through the appeal process, if any;

(4) A statement identifying the specific portion of the decision being appealed and clarifying what is believed to be unlawful or in error;

(5) A statement of facts in support of the appealing party's position;

(6) Any information or documentation that the appealing party would like considered;

(7) The type of relief sought; and

(8) The signature of the appealing party or the appealing party's representative.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 their own ((~~motion~~)). The continuance may be up to thirty calendar days.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2090 Initial order. Unless a continuance has been granted, within ten days after the public employees benefits board (PEBB) appeals unit receives a request for a brief adjudicative proceeding, the presiding officer ((~~shall~~)) must render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The presiding officer must serve a copy of the initial order on all parties and the initial order must contain information on how the appellant may request review of the initial order.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 a 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 make an oral request for review of the initial order with the 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 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 initial order becomes the authority's final order without 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 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 182-16-2110 Final order. (1) A final order issued by the review officer or officers will be ((~~issued~~)) in writing and include a brief statement of the reasons for the decision.

(2) The final order must be ((~~rendered and~~)) served within twenty days of the date of the initial order or of the date the request for review of the initial order was received by the PEBB appeals unit, whichever is later.

(3) The final order will include a notice that reconsideration and judicial review may be available.

(4) A request for review of the initial order is deemed denied if the authority does not issue a final order within twenty days after the request for review of the initial order is filed.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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((~~.~~)); and

(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~~)) officer 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~~)) subsection (4)(a) of this section, 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~~)) request 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~~)) request 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 prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-2150 Review officer or officers—Designation and authority. (1) The designation of a review officer or officers ((~~shall~~)) must be consistent with the requirements of RCW 34.05.491 and the review officer or officers ((~~shall~~)) must not have personally participated in the decision made by the employing agency or PEBB program.

(2) The review officer or officers ((~~shall~~)) must 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; or

(b) Reverse the initial order in whole or in part; or

(c) ((~~Refer~~)) Convert the matter ((~~for~~)) to 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 the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director designates a 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 34.05.476.

(3) Part III describes the general rules and procedures that apply to public employees benefits board (PEBB) benefits formal administrative hearings.

(a) 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 III, the procedural rules adopted in ((~~this~~)) Part III must govern.

(c) If there is a conflict between ((~~this~~)) Part III 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 III 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3030 Authority of the hearing officer. (1) A hearing officer must hear and decide the issues 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 only to preserve the record for judicial review.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 formal administrative hearing under circumstances identified in this 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.

(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 (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 19-17-073, filed 8/20/19, effective 1/1/20)

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 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 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~~)) 182-16-3180 and 182-16-3200.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3130 Subpoenas. (1) Hearing officers, the health care authority (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 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 19-17-073, filed 8/20/19, effective 1/1/20)

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 with good cause 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 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 the 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 except WAC 182-32-3140(8).

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-16-3170 Final order deadline—Required information. (1) Within ninety days after the formal administrative hearing record is closed, the hearing officer must serve ((~~a final order that 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, the hearing officer must:

(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 19-17-073, filed 8/20/19, effective 1/1/20)

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 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~~)) reconsideration, 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~~)) prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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~~)) decide 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 182-16-3180 (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.

WSR 20-16-063
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2020-02—Filed July 28, 2020, 4:25 p.m., effective January 1, 2021]

Effective Date of Rule: January 1, 2021.

Purpose: The purpose is to amend some of the existing rules to support the public employees benefits board (PEBB) program.

1. Implement PEBB Policy Resolution 2020-05:

- Amended WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, and 182-12-265 to implement if a subscriber selects a PEBB program medicare advantage-prescription drug (MAPD) plan, any non-medicare enrollees on the account will be enrolled in the uniform medical plan (UMP) classic.

2. Make technical amendments:

- Amended WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, and 182-12-265 to include enrollment requirements for the medicare advantage (MA) and MAPD plans;
- Amended WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, and 182-12-265 to clarify the use of PEBB retiree insurance coverage and PEBB benefits;
- Amended WAC 182-12-171 and 182-12-180 to clarify enrollment requirements for those who are eligible for medicare to maintain enrollment in both medicare Parts A and B;
- Amended WAC 182-12-171 to clarify substantive eligibility requirements for an employee and a school employee, to clarify an exception for a retiring employee under a retirement plan sponsored by an employer group or tribal government that is not sponsored by Washington state, and to clarify when the enrollee's eligibility will end;
- Amended WAC 182-12-180 to clarify the surviving spouse, state-registered domestic partner, or child of an official must meet procedural requirements to enroll and defer enrollment in PEBB retiree insurance coverage, and to clarify when the enrollee's eligibility will end;
- Amended WAC 182-12-200 to clarify a retiring employee or a retiring school employee may defer PEBB retiree insurance coverage if they meet substantive eligibility requirements, to clarify a retiring employee, a retiring school employee, or a retiree who defers enrollment in PEBB retiree insurance coverage, defers both PEBB medical and PEBB dental and they may later enroll themselves and their dependents;
- Amended WAC 182-12-200 and 182-12-205 to clarify a retiree may only defer enrollment in PEBB retiree term life insurance as described in WAC 182-12-209 (3)(b);
- Amended WAC 182-12-205 to include a WAC reference for the definition of creditable coverage.

Citation of Rules Affected by this Order: Amending WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, and 182-12-265.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; 42 C.F.R. § 422.62(b) and § 423.38(c).

Other Authority: PEBB Policy Resolution 2020-05.

Adopted under notice filed as WSR 20-13-075 on June 16, 2020.

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

Number of Sections Adopted at 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 6, Repealed 0.

Date Adopted: July 28, 2020.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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;

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program no later than the last day of the month prior to the month the employee's or the school employee's employer-paid, COBRA coverage, or continuation coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, a retiring employee or a retiring school employee may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(b) The employee's or the school employee's first premium payment for PEBB retiree insurance coverage ((~~enrollment~~)) 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 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 or medicare advantage-prescription drug 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~~)) retiree insurance coverage, 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 who is eligible for PEBB benefits through an employing agency, or a school employee who is eligible for SEBB benefits through a SEBB organization or basic benefits through an educational service district as defined in RCW 28A.400.270 ((~~and~~)) who 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 retiree insurance coverage ((~~as a retiree~~)), the employee or the school employee must be vested in and 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. An exception to the requirement to be vested in and eligible to retire under a Washington state-sponsored retirement plan is provided for employees of an employer group in (c)(i) of this subsection.

((~~(b)~~)) (a) 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)~~)) (b) 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)~~)) (c) 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 (c)(i) or (ii) of this subsection to be eligible to continue PEBB retiree insurance coverage ((~~as a retiree~~)), except for an educational service district employee who must meet the requirements as described in ((~~subsection (2)(c)~~)) (d) of this ((~~section~~)) subsection.

(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, if their date of hire with that employer group or tribal government was before October 1, 1977, or Plan 2 ((~~during their employment~~)), if their date of hire with that employer group or tribal government was on or after October 1, 1977.

(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)~~)) (a)(i) and (ii) of this ((~~section~~)) subsection.

(iii) A retired employee of an employer group, except a Washington state educational service district, 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.

((~~(c)~~)) (d) A retiring school employee 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) 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~~)) eligible for 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~~)) eligible for 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~~)) eligible for medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee's eligibility will end as described in the termination notice sent by the PEBB program. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(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~~)) benefits at the time of retirement.

AMENDATORY SECTION (Amending WSR 19-17-073, filed 8/20/19, effective 1/1/20)

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 to enroll or defer enrollment 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;

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program before the official leaves public office or no later than the last day of the month prior to the month PEBB insurance coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(b) The official's or survivor's first premium payment and applicable premium surcharges 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 or medicare advantage-prescription drug 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~~)) retiree insurance coverage 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~~)) eligible for medicare or becomes ((~~entitled to~~)) eligible for 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~~)) eligible for medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee's eligibility will end as described in the termination notice sent by the PEBB program. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

Note: For the exclusive purpose of medicare Part A as described in this subsection, "eligible" means the enrollee is eligible for medicare Part A without a monthly premium.

(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 19-17-073, filed 8/20/19, effective 1/1/20)

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 educational service district, or 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~~)) retiree insurance coverage at retirement ((~~or~~)) if they meet substantive eligibility requirements as described in WAC 182-12-171(2) or as described in WAC 182-12-180(1). An enrolled retiree may defer enrollment after enrolling in PEBB retiree insurance coverage. Enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage may be deferred when they are enrolled as a dependent in a health plan sponsored by PEBB, a Washington state educational service district, or ((~~SEBB~~)) school employees benefits board (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 retiring employee, a retiring school employee, or a retiree who defers enrollment in ((~~medical must~~)) PEBB retiree insurance coverage defers enrollment in PEBB medical and PEBB dental. A retiree((~~s~~)) must be enrolled in PEBB medical to enroll in PEBB dental. A retiree who defers enrollment ((~~in a PEBB health plan~~)) also defers enrollment for all eligible dependents. A retiree may only defer enrollment in PEBB retiree term life insurance as described in WAC 182-12-209 (3)(b).

(3) A retiring employee, a retiring school employee, or a retiree who defers enrollment may later enroll themselves and their dependents in a PEBB health plan if they provide evidence of continuous enrollment in a health plan sponsored by PEBB, a Washington state educational service district, or 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 educational service district, or 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.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month the other coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(((~~(4)~~))) (c) If a retiree elects to enroll a dependent in PEBB health plan coverage as described in this subsection, 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 or medicare advantage-prescription drug 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-205 May a retiree or a survivor defer enrollment or voluntarily terminate enrollment under 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~~)) retiree insurance coverage:

(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~~)) retiree insurance coverage 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 chooses to defer((~~s~~)) enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage must maintain continuous enrollment in other medical as described in this section or WAC 182-12-200. A subscriber who chooses to defer((~~s~~)) enrollment, defers enrollment in PEBB medical ((~~must defer enrollment in~~)) and PEBB dental. A subscriber must be enrolled in PEBB medical to enroll in PEBB dental. A retiree may only defer enrollment in PEBB retiree term life insurance as described in WAC 182-12-209 (3)(b).

(a) Beginning January 1, 2001, enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage 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~~)) retiree insurance coverage 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~~)) retiree insurance coverage may be deferred when the subscriber is enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as ((~~described~~)) defined in ((~~this chapter~~)) WAC 182-12-109. 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~~)) retiree insurance coverage when the subscriber is enrolled in exchange coverage.

(e) Beginning July 17, 2018, enrollment in ((~~a~~)) PEBB ((~~health plan~~)) retiree insurance coverage may be deferred when the subscriber is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

(4) To defer enrollment in PEBB ((~~health plan enrollment~~)) retiree insurance coverage, 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, educational service district coverage, or 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, educational service district coverage, or 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~~)) retiree insurance coverage, 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~~)) retiree insurance coverage 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.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month the employer-based group medical, COBRA coverage, or continuation coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(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.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month the federal retiree medical plan coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(c) A subscriber who defers enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as ((~~described~~)) defined in ((~~this chapter~~)) WAC 182-12-109 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

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month medicaid coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(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.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month exchange coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(e) A subscriber who defers enrollment while enrolled 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.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms and evidence of continuous enrollment must be received by the PEBB program no later than the last day of the month prior to the month CHAMPVA coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the subscriber may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(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 as described in this subsection, 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 or medicare advantage-prescription drug 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~~)) retiree insurance coverage 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 19-17-073, filed 8/20/19, effective 1/1/20)

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, 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, 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) The employee or the school employee, at their option, must indicate the 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 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.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive. The employee or the school employee may change health plans to a medicare advantage or medicare advantage-prescription drug plan during a special enrollment period as described in WAC 182-08-198(2).

(3) The director may make an exception to the date of PEBB retiree insurance coverage 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 or medicare advantage-prescription drug 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 19-17-073, filed 8/20/19, effective 1/1/20)

WAC 182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if 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 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.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program no later than the last day of the month prior to the month PEBB insurance coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(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 an educational service district.

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 an educational service district.

(3) A school employee's spouse, state registered domestic partner, or child 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 educational service district coverage, or school employees benefits board (SEBB) insurance coverage ends.

Exception: Enrollment in the PEBB program's medicare advantage or medicare advantage-prescription drug plan may not be retroactive so the required forms must be received by the PEBB program no later than the last day of the month prior to the month the educational service district coverage or SEBB insurance coverage ends. If the forms are received after the date enrollment in PEBB retiree insurance coverage is to begin, the survivor may not select a medicare advantage or medicare advantage-prescription drug plan until a special enrollment period as described in WAC 182-08-198(2).

(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 premiums and applicable premium surcharges received by the HCA are sufficient as described in WAC 182-08-180 (1)(d)(ii) to maintain PEBB health plan enrollment after the 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 or medicare advantage-prescription drug 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~~)) retiree insurance coverage as described in WAC 182-12-200 and 182-12-205.

WSR 20-16-064

PERMANENT RULES

HEALTH CARE AUTHORITY

(School Employees Benefits Board)

[Admin #2020-01—Filed July 28, 2020, 4:42 p.m., effective August 28, 2020]

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

Purpose: The purpose is to amend WAC 182-30-130 to support the school employees benefits board (SEBB) program.

Implement SEBB policy resolutions and make technical amendments: Amended WAC 182-31-040 to make technical corrections for readability and update references as needed for structural changes. Amended subsection (3) to include all hours that a school employee receives compensation from their SEBB organization for a paid holiday or while on approved leave to the hours that count while determining eligibility for SEBB program benefits. Amended subsection (6) to add a new method for a school employee who returns from an approved leave without pay to maintain or establish eligibility. Amended subsection (7) to clarify what benefits are available and the date that they will begin and to add an exception to when benefits are earned in the month of August.

Citation of Rules Affected by this Order: Amending WAC 182-31-040.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: SEBB Policy Resolutions 2020-01, 2020-02, and 2020-05.

Adopted under notice filed as WSR 20-13-072 on June 16, 2020.

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 0, Amended 1, Repealed 0.

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

Date Adopted: July 28, 2020.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-040 How do school employees establish eligibility for the employer contribution toward school employees benefits board (SEBB) benefits and when do SEBB benefits ((~~coverage~~)) begin? (1) Eligibility shall be determined solely by the criteria that most closely describes the school employee's work circumstance.

(2) School employee eligibility criteria:

(a) A school employee is eligible for the employer contribution toward((~~s~~)) school employees benefits board (SEBB) benefits if they are anticipated to work at least six hundred thirty hours per school year. The eligibility effective date for a school employee eligible under this subsection shall be determined as follows:

(i) If the school employee's first day of work is on or after September 1st but not later than the first day of school for the current school year as established by the SEBB organization, they are eligible for the employer contribution on the first day of work; or

(ii) If the school employee's first day of work is at any other time during the school year, they are eligible for the employer contribution on that day.

(b) A school employee who is not anticipated to work at least six hundred thirty hours in the school year becomes eligible for the employer contribution toward((~~s~~)) SEBB benefits on the date their work pattern is revised in such a way that they are now anticipated to work six hundred thirty hours in the school year.

(c) A school employee who is not anticipated to work at least six hundred thirty hours in the school year becomes eligible for the employer contribution toward((~~s~~)) SEBB benefits on the date they actually worked six hundred thirty hours in the school year.

(d) A school employee who is not anticipated to work six hundred thirty hours within the school year because of the time of year they are hired but is anticipated to work at least six hundred thirty hours the next school year, establishes eligibility for the employer contribution toward SEBB benefits as of their first working day if they are:

(i) A nine to ten month school employee anticipated to be compensated for at least seventeen and one-half hours a week in six of the last eight weeks counting backwards from the week that contains the last day of school; or

(ii) A twelve month school employee anticipated to be compensated for at least seventeen and one-half hours a week in six of the last eight weeks counting backwards from the week that contains August 31st, the last day of the school year.

(3) All hours worked by an employee in their capacity as a school employee must be included in the calculation of hours for determining eligibility. All hours for which a school employee receives compensation from a SEBB organization during an approved leave (e.g., sick leave, personal leave, bereavement leave) or a paid holiday must be included when determining how many hours a school employee is anticipated to work, or did work, in the school year.

(4) A school employee may establish eligibility for the employer contribution toward SEBB benefits by stacking of hours from multiple positions within one SEBB organization. A school employee may not gain eligibility by stacking of hours from multiple SEBB organizations.

(5) A school employee is presumed eligible for the employer contribution at the start of the school year, as described in subsection (2)(a) of this section, if they:

(a) Worked at least six hundred thirty hours in each of previous two school years; and

(b) Are returning to the same type of position (teacher, paraeducator, food service worker, custodian, etc.) or combination of positions with the same SEBB organization.

Note: A SEBB organization rebuts this presumption by notifying the school employee, in writing, of the specific reasons why the school employee is not anticipated to work at least six hundred thirty hours in the current school year and how to appeal the eligibility determination.

(6) A school employee who returns from approved leave without pay will maintain or establish eligibility for the employer contribution toward SEBB benefits if their work schedule, had it been in effect at the start of the school year, would have resulted in the school employee being anticipated to work the minimum hours to meet SEBB eligibility for the employer contribution in the school year. A school employee who regains eligibility under this subsection establishes eligibility for the employer contribution toward SEBB benefits as of the date they returned from approved leave without pay.

(7) When SEBB benefits begin:

(a) For a school employee who establishes eligibility under subsection (2)(a)(i) of this section ((~~SEBB benefits~~)), medical, dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, basic long-term disability (LTD) insurance, and if eligible, benefits under the salary reduction plan begin on the first day of work for the new school year. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(b) For a school employee who establishes eligibility under subsection (2)(a)(ii), (b), (c), ((~~or~~)) (d), or (6) of this section, ((~~SEBB insurance coverage~~)) medical, dental, vision, basic life insurance, basic AD&D insurance, basic LTD insurance, and if eligible, benefits under the salary reduction plan begin((~~s~~)) on the first day of the month following the date the school employee becomes eligible for the employer contribution toward((~~s~~)) SEBB benefits. Supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

Exception: When a school employee establishes eligibility for the employer contribution toward SEBB benefits as described under subsection (2)(b) or (c), or (6) of this section, at any time in the month of August, SEBB benefits begin on September 1st only if the school employee is also determined to be eligible for the employer contribution toward SEBB benefits for the school year that begins on September 1st.

(((~~7~~))) (8) If the school employee is not eligible under subsections (1) through (((~~5~~))) (6) of this section, they may be eligible for SEBB benefits if their SEBB organization is engaging in local negotiations regarding eligibility for school employees as described in WAC 182-30-130.

WSR 20-16-065
PERMANENT RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin #2020-02—Filed July 28, 2020, 4:42 p.m., effective August 28, 2020]

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

Purpose: The purpose is to amend WAC 182-30-130 to support the school employees benefits board (SEBB) program.

Implement SEBB policy resolutions and make technical amendments: Amended WAC 182-30-130 to clarify that a SEBB organization, engaging in local negotiations regarding SEBB benefits eligibility criteria, must establish a threshold of anticipated work hours no less than one hundred eighty hours but less than the minimum hours to meet SEBB eligibility under WAC 182-31-040 within a school year.

Citation of Rules Affected by this Order: Amending WAC 182-30-130.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: SEBB Policy Resolutions 2020-04.

Adopted under notice filed as WSR 20-13-071 on June 16, 2020.

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 0, Amended 1, Repealed 0.

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

Date Adopted: July 28, 2020.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-130 What are the requirements for a school employees benefits board (SEBB) organization engaging in local negotiations regarding SEBB benefits eligibility criteria? This section describes the terms and conditions for a school employees benefits board (SEBB) organization that is engaging in local negotiations regarding eligibility for school employees as described in RCW 41.05.740 (6)(e).

(1) A SEBB organization must provide a current ratified collective bargaining agreement (CBA) and information on all eligible school employees under the CBA to the health care authority (HCA) by the start of the school year.

(2) A SEBB organization must offer all of, and only, the following SEBB benefits to employees and their dependents:

(a) Medical (includes the wellness incentive);

(b) Dental;

(c) Vision;

(d) Basic life;

(e) Basic accidental death and dismemberment (AD&D) insurance.

(3) A SEBB organization must provide an employer contribution as described below:

(a) The subscriber-only employer medical contribution (EMC) amount for school employees eligible under RCW 41.05.740 (6)(d) multiplied by the premium tier ratio associated with the enrollment tier selected by the school employee;

(b) One hundred percent of the cost for the school employee dental plan multiplied by the enrollment tier selected by the school employee;

(c) One hundred percent of the cost for the school employee vision plan multiplied by the enrollment tier selected by the school employee;

(d) One hundred percent of the cost for basic life and accidental death and dismemberment (AD&D) insurance;

(e) One hundred percent of the cost of the administrative fee charged by the HCA; and

(f) One hundred percent of the monthly K-12 remittance for deposit in the retired school employees' subsidy account.

(4) A SEBB organization providing SEBB benefits as described in this section may do so by group as described in (a) through (d) of this subsection:

(a) The entire SEBB organization;

(b) A entire collective bargaining unit;

(c) A group containing all nonrepresented school employees; or

(d) A combination of (b) and (c) of this subsection.

(5) A SEBB organization must establish a threshold of anticipated work hours no less than one hundred eighty hours ((~~and no more~~)) but less than the minimum hours to meet SEBB eligibility under WAC 182-31-040 within a school year.

(6) All of the rules in chapters 182-30, 182-31, and 182-32 WAC apply, except for all rules governing SEBB benefits that are not available to school employees whose eligibility is established under this section. The following benefits are not available to school employees whose eligibility is established under this section:

(a) Long-term disability (LTD);

(b) Medical flexible spending arrangement (FSA);

(c) Dependent care assistance program (DCAP); and

(d) Supplemental life insurance.

(7) If a school employee waives medical under this section, there is no requirement to send the employer contribution to the HCA as required in WAC 182-30-070(4).

(8) Eligibility determinations must align with the SEBB program's status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means the SEBB organization may only consider school 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.

(9) A SEBB organization providing SEBB benefits to a group of school employees under this section must notify the SEBB program each time the CBA is renegotiated.

WSR 20-16-066
PERMANENT RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin #2020-03—Filed July 28, 2020, 4:44 p.m., effective August 28, 2020]

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

Purpose: The purpose is to amend WAC 182-30-060 to support the school employees benefits board (SEBB) program with the following:

1. Implementing SEBB Policy Resolution 2020-06: If a benefits administrator or a contracted vendor provides incorrect advice regarding SEBB benefits to a school employee that they relied upon, the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The health care authority approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted.

2. Made technical amendments to clarify when a SEBB organization or contracted vendor must correct enrollment errors, to clarify enrollment and termination requirements, to include premium payments and premium refund requirements, and to include recourse provisions.

Citation of Rules Affected by this Order: Amending WAC 182-30-060.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: SEBB Policy Resolution 2020-06.

Adopted under notice filed as WSR 20-13-070 on June 16, 2020.

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 0, Amended 1, Repealed 0.

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

Date Adopted: July 28, 2020.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-060 How do school employees benefits board (SEBB) organizations and contracted vendors correct enrollment errors? ((~~(1) If a SEBB organization fails to provide notice of benefits eligibility or accurately enroll a school employee or their dependents in benefits, the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The health care authority approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted.~~

~~(2) If a SEBB organization errs and enrolls a school employee or their dependents in SEBB insurance coverage when they are not eligible and there was no fraud or intentional misrepresentation by the school employee involved, premiums and any applicable premium surcharges already paid by the school employee will be refunded by the SEBB organization to the school employee. The error will be corrected prospectively with termination of benefits effective the first day of the month following the date the error is identified.~~)) (1) A school employees benefits board (SEBB) organization or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (5) of this section.

(a) Failure to timely notify a school employee of their eligibility for SEBB benefits and the employer contribution as described in WAC 182-31-030;

(b) Failure to enroll a school employee or their dependents in SEBB benefits as elected by the school employee, if the election was timely;

(c) Failure to enroll a school employee and their dependents in SEBB benefits as described in WAC 182-30-080 (1)(b);

(d) Failure to accurately reflect a school employee's premium surcharge attestation on the school employee's account;

(e) Enrolling a school employee or their dependents in SEBB insurance coverage when they are not eligible as described in WAC 182-31-040 or 182-31-140 and it is clear there was no fraud or intentional misrepresentation by the school employee involved; or

(f) Providing incorrect information, via a benefits administrator or contracted vendor, regarding SEBB benefits to the employee that they relied upon.

(2) The SEBB organization or the applicable contracted vendor must enroll the school employee and the school employee's dependents, as elected, or terminate enrollment in SEBB benefits as described in subsection (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (4) of this section, and provide recourse as described in subsection (5) of this section.

(3) **Enrollment or termination.**

(a) SEBB medical, vision, 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 (5) of this section;

(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 school employee became newly eligible, or the first day of the month the school employee regained eligibility, as described in WAC 182-30-080;

(c) Supplemental life, supplemental AD&D, and supplemental LTD insurance enrollment is retroactive to the first day of the month following the day the school employee became newly eligible if the school employee elects to enroll in this coverage (or if previously elected, the first of the month following the signature date on the school employee's application for this coverage). If a SEBB organization enrollment error occurred when the school employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-30-080(3).

(i) Supplemental life and supplemental AD&D is enrolled the first day of the month the school employee regained eligibility, at the same level of coverage the school employee continued during the period of leave, without evidence of insurability.

(ii) If the school employee was eligible to continue supplemental life insurance and supplemental AD&D insurance during the period of leave but did not, the school employee must provide evidence of insurability and receive approval from the contracted vendor.

(iii) School employees may not continue supplemental LTD insurance while on leave without pay as described in WAC 182-31-100. Supplemental LTD insurance is reinstated the first day of the month the employee regains eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(d) If the school 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 a school employee was not enrolled in a medical FSA or DCAP as elected, the school 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 school 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 SEBB benefits will be terminated prospectively effective as of the last day of the month.

(4) **Premium payments.**

(a) The SEBB organization must remit to the authority the employer contribution and the school employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and basic LTD starting the date SEBB benefits begin as described in subsections (3) and (5)(a)(i) of this section. If a SEBB organization failed to notify a newly eligible school employee of their eligibility for SEBB benefits, the SEBB organization may only collect the school employee contribution for health plan premiums and applicable premium surcharges for coverage for the months after the school employee was notified.

(b) When a SEBB organization fails to correctly enroll the amount of supplemental LTD insurance elected by the school employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the school employee is responsible for premiums for the most recent twenty-four months of coverage. The SEBB organization is responsible for additional months of premiums; and

(ii) When a premium refund is due to the school employee, the supplemental LTD insurance contracted vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The SEBB organization is responsible for additional months of premium refunds after the twenty-four months of coverage and the overall refunding process to the school employee.

(c) When a SEBB organization mistakenly enrolls a school employee or their dependents as described in subsection (1)(e) of this section, premiums and any applicable premium surcharges will be refunded by the SEBB organization to the school employee without rescinding the insurance coverage.

(5) **Recourse.**

(a) School employee eligibility for SEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-31-040. Dependent eligibility is described in WAC 182-31-140, and dependent enrollment is described in WAC 182-31-150. When retroactive correction of an enrollment error is limited as described in subsection (3)(b), (c), and (d) of this section, the SEBB organization must work with the school employee, and receive approval from the authority, to implement retroactive SEBB benefits within the following parameters:

(i) Retroactive enrollment in a SEBB insurance coverage;

(ii) Reimbursement of claims paid;

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

(iv) Reimbursement of amounts paid by the school employee for the premium surcharges;

(v) Other legal remedy received or offered; or

(vi) 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 SEBB benefits.

WSR 20-16-067

PERMANENT RULES

HEALTH CARE AUTHORITY

(School Employees Benefits Board)

[Admin #2020-04—Filed July 28, 2020, 5:06 p.m., effective August 28, 2020]

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

Purpose: The purpose is to create new rules and to amend some of the existing rules to support the school employee benefits board (SEBB) program.

1. Statutory changes:

- Amended WAC 182-30-070 to include paid family and medical leave program for the employer contribution to be maintained when a school employee is on such leave and for enrolled dependents;
- Created WAC 182-30-140 to establish a process for school districts to offer optional benefits based on HB 2458.

2. Make technical amendments:

- Amended chapters 182-30, 182-31, and 182-32 WAC with global changes to update the use of health plan, insurance coverage, benefits, and specific benefits;
- Within the definitions sections of chapters 182-30, 182-31, and 182-32 WAC:
  - Amended the definition of "Continuation coverage" to allow continuation of benefits instead of health plan coverage;
  - Amended the definition of "Employer-based group health plan" and revising it to "Employer-group medical" within WAC 182-32-020, added the new definition of "Employer-based group medical." within chapters 182-30 and 182-31 WAC;
  - Amended the definition of "Health plan" by replacing the word "SEBB" with "board";
  - Amended the definition of "Life insurance" to align all definitions within all three chapters for consistency;
  - Amended the definition of "LTD insurance" by spelling out the acronym;
  - Removed the definition of "Public employees benefits board" or "PEBB" and replaced it with a new definition of "PEBB"; and
  - Amended the definition of "SEBB" by removing the reference to RCW 41.05.740.
- Added the definition of "Board" in WAC 182-31-020 and 182-32-020.
- Aligned the definition of "Calendar days" or "days" in WAC 182-31-020 and 182-32-020.
- Amended WAC 182-30-020 to add a definition of "Benefits administrator."
- Amended WAC 182-32-020 the definition of "Business days" to include "state" when referencing legal holidays to align with statute.
- Amended WAC 182-30-040 to clarify insurance coverage for premiums and applicable premium surcharges, updated WAC citations, clarified where premium payments go to, and clarified when a subscriber's account becomes delinquent for subscribers that are not eligible for the employer contribution.
- Amended WAC 182-30-050 to clarify the exception regarding waiving and not incurring a surcharge when a school employee's spouse or state registered domestic partner is eligible for SEBB medical.
- Amended WAC 182-30-070 to clarify insurance instead of benefits and to require school employees on Paid Family and Medical Leave keep the employer contribution.
- Amended WAC 182-30-075 to align language with the SEBB appeal rules and add acronyms.
- Within WAC 182-30-080:

- Updated internal references;
- Clarified a school employee's participation in the salary plan ends when they lose eligibility for the employer contribution;
- Clarified that forms may be submitted to the contracted vendor;
- Clarified requirement to apply for accidental death and dismemberment insurance;
- Correctly named the surcharges;
- Improved readability;
- Clarified requirements for school employees who continued paying for supplemental life insurance; and
- Clarified enrollment for returning school employees who do not make elections.

- Rescinded WAC 182-30-081 addressing the requirements of the first SEBB annual open enrollment period.
- Amended WAC 182-30-085 to provide clarity on what happens when a health plan becomes unavailable or a school employee loses eligibility for a health plan.
- Within WAC 182-30-090:
  - Amended this section to clarify eligibility regarding special open enrollment by including two WAC references;
  - Clarified that gaining initial eligibility or regaining eligibility does not create a special open enrollment;
  - Added information about timing of benefits for extended or disabled dependents; and
  - Updated language in medicaid, medicare, and state children's health insurance program special open enrollment for clarity.
- Amended WAC 182-30-100 to clarify that either a school employee or their dependent enrolls in coverage or loses coverage under medicare, updated language in medicaid, medicare, and state children's health insurance program special open enrollments for clarity, and updated internal references in the note. Clarified school employees, not subscribers, may make changes and that medical plans may not be changed unless the change aligns with the cafeteria plan rules and to clarify for a subscriber who has a change in employment from a SEBB organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon.
- Amended WAC 182-31-030 to address school employees who receive a notice in writing of eligibility must have no less than ten calendar days to elect coverage and technical corrections to use the updated definitions.
- Amended WAC 182-31-050 to clarify that benefits will be termed the last day of the month premiums were deducted to prevent a rescission, and school employee premiums must be refunded if deducted in advance when no longer eligible.
- Amended WAC 182-31-070 to clarify medical, dental, and vision coverage is limited to a single enrollment per individual and clarified that an eligible school employee may only waive SEBB medical and enroll as a dependent under the medical plan of their spouse, state registered domestic partner, or parent.
- Amended WAC 182-31-080 to clarify returning from waiving SEBB medical in the events regarding medicaid and state children's health insurance program and changed "entitled to" to "enrolled in" for special open enrollment events regarding medicaid and state children's health insurance program, and updated language in medicaid, medicare, and state children's health insurance program special open enrollments for clarity.
- Amended WAC 182-31-090 to clarify that a school employee or their dependent may continue SEBB medical, dental, or vision under Consolidated Omnibus Budget Reconciliation Act (COBRA) and clarified a subscriber's state registered domestic partner and their children may continue SEBB medical, dental, or vision on the same terms and conditions as a spouse and other eligible dependents, added specific reference to the premium payment rule, and made minor changes for readability.
- Rescinded WAC 182-31-091 that describes SEBB continuation coverage for school employees and their dependents not eligible for SEBB benefits only applied during go-live of the SEBB program.
- Amended WAC 182-31-100 to clarify continuation coverage regarding life and accidental death and dismemberment insurance including supplemental coverages, clarified that "coverage" not "benefits" may be continued, made changes for readability, and updated references.
- Amended WAC 182-31-110 to clarify, add details, and update references about the Paid Family and Medical Leave Program and the employer contribution, and removed language to no longer allow insurance coverage to be terminated for non-payment when a school employee is on Family Medical and Leave Act or Paid Family and Medical Leave.
- Amended WAC 182-31-120 to add a "court" as an entity to review a dismissal action to the list of decision makers, specify coverage "terminates" rather than "ends," and specify school employees "may enroll in" supplemental coverage rather than having coverage "restored" if retroactive premiums are not received.
- Within WAC 182-31-130:
  - Amended this section to clarify the dependent's first premium payment and applicable premium surcharges due date based on the applicable citations, specified that medical, dental, and vision premiums and applicable premium surcharges must be made to HCA;
  - Clarified that a school employee or their dependent may continue SEBB medical, dental, or vision under COBRA and clarified a subscriber's state registered domestic partner and their children may continue SEBB medical, dental, or vision on the same terms and conditions as a spouse and other eligible dependents under COBRA, and added specific reference to the premium payment rule.
- Amended WAC 182-31-140 to clarify that a dependent will not be enrolled in a health plan coverage if the SEBB program or SEBB organization is unable to verify eligibility within the timelines, removed specific lan-

guage regarding providing notice of loss of eligibility and noted appropriate reference. In addition, clarified that verification will require renewed proof for disability and dependence for a child twenty-six or older.

- Within WAC 182-31-150:
  - Clarified the effective dates of insurance coverage and supplemental dependent life and AD&D insurance;
  - Removed language regarding newborn child having an effective date for supplemental dependent life or AD&D insurance on the date the child becomes fourteen days old;
  - Included new language concerning a newborn child regarding supplemental coverages, effective dates, and requirements;
  - Included new language regarding a National Medical Support Notice which allows a subscriber to add or remove dependents, and specified for clarity the enrollment and removal requirements for supplemental dependent life and AD&D insurance; and
  - Clarified enrollment in medicaid or a state children's health insurance program.
- Amended WAC 182-31-160 clarifying when a dependent already enrolled may be removed from health plan coverage regarding National Medical Support Notice.
- Amended WAC 182-31-190 to remove language regarding the $50 wellness incentive as a reduction for plan year 2020, clarified that subscribers must be eligible to complete the SEBB wellness incentive requirements, and clarified that the subscriber has to be enrolled in a SEBB medical plan the year the incentive applies. Additionally, changed "SEBB Program" to "contracted vendor" regarding different means to earn the incentive.
- Amended chapter 182-32 WAC with global fixes throughout replacing the word "shall" to "must" for consistency.
- Amended WAC 182-32-058 to clarify that a party may prove a service from a signed affidavit of mailing or certificate of the service.
- Amended WAC 182-32-066 to clarify a reference to a standard of proof.
- Amended WAC 182-32-120 to clarify state legal holiday.
- Amended WAC 182-32-130 to clarify that a final order is what is relied upon, not a decision.
- Amended WAC 182-32-2020 to clarify a timeline for appeals when the SEBB organization fails to render a decision within thirty days.
- Amended WAC 182-32-2030 to clarify when failing to request a brief adjudicative proceeding that the language in this section maintains consistency with other sections.
- Amended WAC 182-32-2040 to clarify language regarding the subscriber failing to timely request for a brief adjudicative proceeding for the wellness incentive program and maintain consistency with other sections within the chapter.
- Amended WAC 182-32-2050 to clarify a timeline for appeals when the SEBB organization fails to render a decision within thirty days.
- Amended WAC 182-32-2085 to clarify when they request for a continuance, they can on their own.
- Amended WAC 182-32-2100 to clarify the initial order by maintaining consistency with other sections within chapter 182-32 WAC.
- Amended WAC 182-32-2110 to make a technical correction and narrowed down the provision of the final order.
- Amended WAC 182-32-2120 to clarify that an appellant is not petitioning for a reconsideration.
- Amended WAC 182-32-2150 to clarify that a brief adjudicative proceeding can be converted into a formal administrative hearing not referred.
- Amended WAC 182-32-2160 to clarify that a representative, the authority, or presiding officer or review officer or officers can convert a brief adjudicative proceeding on their own.
- Amended WAC 182-32-3015 to clarify that the hearing officer must serve the order no later than seven days after receiving the petition for disqualification.
- Amended WAC 182-32-3100 to specify rescheduling the formal administrative hearing and removed the requirement to immediately telephone all other parties in the event of a continuance.
- Amended WAC 182-32-3120 to update references.
- Amended WAC 182-32-3140 to update "good cause" requirements, update references, and make a minor change for readability.
- Amended WAC 182-32-3170 to clarify that a final order is the authority's final decision by removing the redundancy as it is a defined term.
- Amended WAC 182-32-3180 to clarify what new information may be introduced.
- Amended WAC 182-32-3190 by replacing "dispose of" with "decide."

3. Amend rules to improve administration of the SEBB program:

- Amended WAC 182-32-010 to remove the acronym.
- Amended WAC 182-32-020 to add quotations to the definition of "contracted vendor," clarified that "disability insurance" applied to school employees, changed "employer-based group health plan" to "employer-based group medical," updated the definition of "file" to refer to a defined term, and removed acronyms in the definition of "salary reduction plan."
- Amended WAC 182-32-3000 referencing Part III of chapter 182-32 WAC to maintain consistency and improve readability.

Citation of Rules Affected by this Order: New WAC 182-30-140; repealing WAC 182-30-081 and 182-31-091; and amending 182-30-020, 182-30-040, 182-30-050, 182-30-070, 182-30-075, 182-30-080, 182-30-085, 182-30-090, 182-30-100, 182-31-020, 182-31-030, 182-31-050, 182-31-070, 182-31-080, 182-31-090, 182-31-100, 182-31-110, 182-31-120, 182-31-130, 182-31-135, 182-31-140, 182-31-150, 182-31-160, 182-31-190, 182-32-010, 182-32-020, 182-32-058, 182-32-066, 182-32-120, 182-32-130, 182-32-2010, 182-32-2020, 182-32-2030, 182-32-2040, 182-32-2050, 182-32-2085, 182-32-2090, 182-32-2100, 182-32-2110, 182-32-

2120, 182-32-2140, 182-32-2150, 182-32-2160, 182-32-3000, 182-32-3015, 182-32-3100, 182-32-3120, 182-32-3140, 182-32-3170, 182-32-3180, and 182-32-3190.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; HB 2458, chapter 231, Laws of 2020.

Adopted under notice filed as WSR 20-13-069 on June 16, 2020.

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

Number of Sections Adopted at 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 51, 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 1, Amended 51, Repealed 2.

Date Adopted: July 28, 2020.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-020 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 SEBB organization, as well as supplemental accidental death and dismemberment insurance offered to and paid for by school employees for themselves and their dependents.

"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, enroll in coverage, or waive enrollment in SEBB medical. School employees participating 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 administrator" means any person or persons designated by the SEBB organization that trains, communicates, and interacts with school employees as the subject matter expert for eligibility, enrollment, and appeals for SEBB benefits.

"Board" means the school employees benefits board established under provisions of RCW 41.05.740.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all ((~~legal~~)) state legal 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~~)) SEBB benefits available to enrollees 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 SEBB 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 SEBB 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 SEBB benefits.

"Dependent" means a person who meets eligibility requirements in WAC 182-31-140.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby school employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under 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.

"Employer-based group health plan" means group medical, group vision, and group dental related to a current employment relationship. It does not include medical, vision, 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 HCA by a school employees benefits board (SEBB) organization for its eligible school employees as described under WAC 182-31-040 or 182-30-130.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-31 WAC or WAC 182-30-130, who is enrolled in SEBB benefits, and for whom applicable premium payments have been made.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical, vision, dental, or any combination of these coverages, developed by the ((~~SEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of $50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

"Life insurance" means ((~~any~~)) basic life insurance paid for by the SEBB organization, as well as supplemental life insurance offered to and paid for by school employees for themselves and their dependents.

"Long-term disability insurance" or "LTD insurance" ((~~or "long-term disability insurance"~~)) means any basic long-term disability insurance paid for by the SEBB organization and any supplemental long-term disability insurance offered to and paid for by the school employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible school 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 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.

"Premium payment plan" means a benefit plan whereby school 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 employees benefits board" or "PEBB" means the board established under RCW 41.05.055.~~))

"Salary reduction plan" means a benefit plan whereby school employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" means:

• All employees of school districts and charter schools established under chapter 28A.710 RCW;

• Represented employees of educational service districts; and

• Effective January 1, 2024, all employees of educational service districts.

"School employees benefits board organization" or "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.

"School year" means school year as defined in RCW 28A.150.203(11).

"SEBB" means the school employees benefits board ((~~established in RCW 41.05.740~~)).

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

"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 program" means the program within the HCA that administers insurance and other benefits for eligible school employees (as described in WAC 182-31-040 or 182-30-130) and eligible dependents (as described in 182-31-140).

"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, school employees may enroll in or waive enrollment in SEBB medical. School 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 SEBB benefits, see WAC 182-30-090, 182-30-100, 182-31-080, and 182-31-150.

"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 school employee or continuation coverage enrollee who has been determined eligible by the SEBB program or SEBB organization, is enrolled in SEBB benefits, and is the individual to whom the SEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the school employee in addition to the basic coverage provided by the school employees benefits board (SEBB) organization.

"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.

"Waive" means an eligible school employee affirmatively declining enrollment in ((~~a~~)) SEBB ((~~health plan~~)) medical because the school employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), or medicare as allowed under WAC 182-31-080.

"Week" means a seven-day period starting on Sunday and ending on Saturday.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-040 Premium payments and premium refunds. School employees benefits board (SEBB) ((~~benefits~~)) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when a SEBB organization is correcting its enrollment error as described in WAC 182-30-060 (4) or (5).

(1) **Premium payments.** SEBB ((~~benefits~~)) insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which SEBB ((~~benefits are~~)) insurance is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of SEBB ((~~benefits~~)) 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 continuation coverage as described in WAC 182-31-090, ((~~182-31-091,~~)) 182-31-100, 182-31-120, or 182-31-130, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) or the contracted vendor 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 SEBB medical must be made to the HCA as well as premiums associated with continuing SEBB dental or vision insurance coverage. Premiums associated with life insurance coverage and accidental death and dismemberment (AD&D) 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 school employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the SEBB organization. If a school employee elects supplemental coverage, the school employee is responsible for payment of premiums from the month the supplemental coverage begins.

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the SEBB organization, subscriber, or a subscriber's legal representative to the HCA or the contracted vendor. For subscribers not eligible for the employer contribution ((~~or school employees eligible for the employer contribution as described in WAC 182-31-110~~)), 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~~)) subscriber, who is not eligible for the employer contribution, has monthly premiums or applicable premium surcharges remain unpaid for sixty days from the original due date, the subscriber's SEBB ((~~benefits~~)) 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 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 or the contracted vendor 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 or the contracted vendor 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.** SEBB ((~~benefits~~)) 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 SEBB organization any excess premiums and applicable premium surcharges paid during the three month adjustment period, except as indicated in WAC 182-31-120.

(b) If a SEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-32-2010, and provides clear and convincing evidence of extraordinary circumstances, such that 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 SEBB director, the SEBB director's designee, or the SEBB appeals unit may:

(i) Approve a refund of premiums and applicable premium surcharges that 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 SEBB director or the SEBB director's designee.

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

(e) SEBB organization errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the school employee or beneficiary as described in WAC 182-30-060 (4) and (5).

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-050 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 school employees benefits board (SEBB) medical engages in tobacco use. The subscriber must attest as described in (a)(i) through (v) of this subsection:

(i) A school employee who is newly eligible or regains eligibility for the employer contribution toward SEBB benefits must complete the required form to enroll in SEBB medical as described in WAC 182-30-080 (1) or (3). The school employee must include their attestation on that form. The school employee must submit the form to their SEBB organization. If the school employee's attestation results in a premium surcharge, it will take effect the same date as SEBB medical begins;

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's SEBB medical, the subscriber must update their attestation on the required form. A school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit their updated form to the SEBB 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 SEBB medical as described in WAC 182-31-150, the subscriber must attest for their dependent on the required form. A school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit their form to the SEBB program. A change that results in a premium surcharge will take effect the same date as SEBB medical begins;

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-31-090, 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 SEBB program. An attestation that results in a premium surcharge will take effect the same date as SEBB medical begins; or

(v) A school employee who previously waived SEBB medical must complete the required form to enroll in SEBB medical as described in WAC 182-31-080(3). The school employee must submit their attestation on that form. A school employee must submit the form to their SEBB organization. An attestation that results in a premium surcharge will take effect the same date as SEBB medical begins.

Note: A school employee who waives SEBB medical as described in WAC 182-31-080 is not required to provide an attestation and no premium surcharge will be applied to their account as long as the school 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 (a) of this subsection.

(c) The SEBB program will provide reasonable alternatives 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 SEBB 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 website at https://teen.smokefree.gov.

(iii) A subscriber may contact the SEBB 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 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 a school 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 the PEBB UMP Classic's benefits.

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

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in SEBB medical as described in WAC 182-31-150. The subscriber must complete the required form to enroll their spouse or state registered domestic partner, and include their attestation on that form. The school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit the form to the SEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as SEBB medical begins.

(ii) 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 a school 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. A school employee must submit the form to their SEBB organization. A subscriber on continuation coverage must submit the form to the SEBB 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.

(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. A school employee must submit the form to their SEBB organization no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes. A subscriber on continuation coverage must submit the form to the SEBB 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 school employee who waives SEBB medical as described in WAC 182-31-080 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.

(2) A school employee who covers their spouse or state registered domestic partner who has waived their own SEBB medical must attest as described in this subsection, but ((~~a~~)) will not incur a premium surcharge if the school employee provides an attestation that their spouse or state registered domestic partner is eligible for SEBB ((~~coverage~~)) medical.

(3) 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 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 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-070 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible school employees. School employees benefits board (SEBB) organizations must pay the employer contributions to the health care authority (HCA) for SEBB ((~~benefits~~)) insurance coverage for all eligible school employees and their enrolled dependents.

(1) Employer contributions 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. The employer contribution for school employees eligible under RCW 41.05.740 (6)(e) are set by the HCA.

(2) Employer contributions must include an amount determined by the HCA to pay administrative costs to administer SEBB benefits ((~~coverage~~)) for school employees.

(3) ((~~Eligible~~)) Each school employee of a SEBB organization on leave under the federal Family and Medical Leave Act (FMLA) or the paid family medical leave program is eligible for the employer contribution as described in WAC 182-31-110.

(4) The entire employer contribution is due and payable to HCA even if SEBB medical is waived as described in WAC 182-31-080, except for school employees eligible under WAC 182-30-130.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-075 Subscriber address requirements. (1) All school employees must provide their school employees benefits board (SEBB) organization with their correct address and update their address if it changes. A subscriber on continuation coverage must provide the SEBB program with their correct address and updates to their address if it changes.

(2) ((~~School employees who are appealing a decision to the school employees benefits board (SEBB) program~~)) In the event of an appeal, the appellant must update their address as required in WAC 182-32-055.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-080 When must a newly eligible school employee, or a school employee who regains eligibility for the employer contribution, elect school employees benefits board (SEBB) benefits and complete required forms? A school employee who is newly eligible or who regains eligibility for the employer contribution toward school employees benefits board (SEBB) benefits enrolls as described in this section.

(1) When a school employee is newly eligible for SEBB benefits:

(a) A school employee must complete the required forms indicating their enrollment elections, including an election to waive SEBB medical provided the school employee is eligible to waive SEBB medical and elects to waive as described in WAC 182-31-080. The required forms must be returned to the school employee's SEBB organization or contracted vendor. Their SEBB organization or contracted vendor must receive the forms no later than thirty-one days after the school employee becomes eligible for SEBB benefits under WAC 182-31-040.

(i) The school employee may enroll in supplemental life((~~, supplemental accidental death and dismemberment (AD&D),~~)) and supplemental long-term disability (LTD) insurance up to the guaranteed issue coverage amount without evidence of insurability if the required forms are returned to the school employee's SEBB organization or contracted vendor as required. ((~~The~~)) A school employee may apply for

enrollment in supplemental life((~~, supplemental AD&D,~~)) and supplemental LTD insurance over the guaranteed issue coverage amount at any time during the calendar year by submitting the required form to the contracted vendor for approval. A school employee may enroll in supplemental accidental death and dismemberment (AD&D) insurance at anytime without evidence of insurability by submitting the required form to the contracted vendor.

(ii) If the school employee is eligible to participate in the salary reduction plan (see WAC 182-31-060), the school employee will automatically enroll in the premium payment plan upon enrollment in SEBB medical allowing medical premiums to be taken on a pretax basis. To opt out of the premium payment plan, a new school employee must complete the required form and return it to their SEBB organization. The form must be received by their SEBB organization no later than thirty-one days after the employee becomes eligible for SEBB benefits.

(iii) If a school employee is eligible to participate in the salary reduction plan (see WAC 182-31-060), the school 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 ((~~supplemental~~)) SEBB benefits, the school employee must return the required form to their SEBB organization. The form must be received by the SEBB organization no later than thirty-one days after the school employee becomes eligible for SEBB benefits.

(b) If a newly eligible school employee's SEBB organization, or the authority's contracted vendor in the case of life insurance ((~~or accidental death and dismemberment (AD&D)~~)) and AD&D, does not receive the school employee's required forms indicating medical, dental, vision, life insurance, AD&D insurance, and LTD insurance elections, and the school employee's tobacco use status attestation within thirty-one days of the school employee becoming eligible, their enrollment will be as follows for those elections not received within thirty-one days:

(i) A medical plan ((~~as~~)) determined by the health care authority (HCA);

(ii) A dental plan ((~~as~~)) determined by the HCA;

(iii) A vision plan ((~~as~~)) determined by the HCA;

(iv) Basic life insurance;

(v) Basic AD&D insurance;

(vi) Basic LTD insurance;

(vii) Dependents will not be enrolled; and

(viii) A tobacco use premium surcharge will be incurred as described in WAC 182-30-050 (1)(b).

(2) The employer contribution toward SEBB benefits ((~~coverage~~)) ends according to WAC 182-31-050. When a school employee's employment ends, participation in the salary reduction plan ends.

(3) When a school employee regains eligibility for the employer contribution toward SEBB benefits ((~~coverage~~)), including following a period of leave ((~~(~~)) as described in WAC 182-31-100(1)((~~)~~)) or 182-31-040(6), SEBB medical, dental, and vision begin the first day of the month following the school employee's return to work ((~~as~~)) if the SEBB organization anticipates the school employee is eligible for the employer contribution.

(a) ((~~The~~)) A school employee must complete the required forms indicating their enrollment elections, including an election to waive SEBB medical if the school employee chooses to waive SEBB medical as described in WAC 182-31-080. The required forms must be returned to the school employee's SEBB organization except as described in (d) of this subsection. Forms must be received by the SEBB organization, life insurance contracted vendor, or AD&D contracted vendor, if required, no later than thirty-one days after the school employee regains eligibility except as described in (a)(i) and (b) of this subsection:

(i) A school employee who self-paid for supplemental ((~~SEBB~~)) life insurance ((~~coverage or SEBB AD&D insurance~~)) or supplemental AD&D coverage after losing eligibility will ((~~have~~)) maintain that level of coverage ((~~reinstated without evidence of insurability effective the first day of the month in which the school employee regains eligibility for the employer contribution toward SEBB benefits~~)) upon return;

(ii) A school employee who was eligible to continue supplemental life or supplemental AD&D insurance but discontinued that SEBB ((~~insurance~~)) supplemental coverage must submit evidence of insurability to the contracted vendor if they choose to reenroll when they regain eligibility for the employer contribution.

(b) A school employee does not have to return a form indicating supplemental LTD insurance elections. Their supplemental LTD insurance will be automatically reinstated effective the first day of the month they regain eligibility for the employer contribution toward SEBB benefits.

(c) If a school employee's SEBB organization, or contracted vendor accepting forms directly, does not receive the required forms within thirty-one days of the school ((~~employee's enrollment in SEBB, insurance coverage~~)) employee regaining eligibility, the school employee's enrollment for those elections not received will be as described in subsection (1)(b)(i) through ((~~(v) and (vii)~~)) (viii) of this section, except as described in (a)(i) and (b) of this subsection.

(d) If a school employee is eligible to participate in the salary reduction plan (see WAC 182-31-060), the school employee may enroll in the medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these ((~~supplemental~~)) SEBB benefits, the school employee must return the required form to the contracted vendor ((~~of~~)) or their SEBB organization. The contracted vendor or school employee's SEBB organization must receive the form no later than thirty-one days after the school employee becomes eligible for SEBB benefits.

(4) If a school employee who is eligible to participate in the salary reduction plan (see WAC 182-31-060) is hired into a new position ((~~and~~)) that is anticipated to be eligible for SEBB benefits in the same year, the school 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 school employee must notify the new SEBB organization of the transfer by providing the new SEBB organization the required form no later than thirty-one days after the school employee's first day of work with the new SEBB organization.

(5) A school employee will have uninterrupted coverage when moving from one SEBB organization to another within the same month or a consecutive month if they are eligible for the employer contribution towards SEBB benefits in the position they are leaving and are anticipated to be eligible for the employer contribution in the new position. SEBB ((~~insurance coverage~~)) benefits elections also remain the same when a school employee has a break in employment that does not interrupt their employer contribution toward SEBB ((~~insurance coverage~~)) benefits.

(6) A school employee returning to the same SEBB organization who is anticipated to work at least six hundred thirty hours in the coming school year, and who was receiving the employer contribution in August of the prior school year, will receive uninterrupted coverage from one school year to the next.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-085 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) A subscriber must select a new health plan ((~~during the school employees benefits board (SEBB) annual open enrollment period~~)) when their previously selected health plan becomes unavailable due to a change in contracting service area((~~. The required forms must be received no later than the last day of the annual open enrollment.~~)) 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) A school employee must submit the required form to their school employees benefits board (SEBB) organization electing their new health plan.

(((~~b) A subscriber on continuation coverage~~)) (ii) All other subscribers must submit the required forms to the SEBB program electing their new health plan.

(((~~c~~))) (iii) The effective date of the change in ((~~their~~)) health plan will be ((~~January 1st of the following year.~~

~~(2)~~))) 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 plans 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 SEBB annual open enrollment.

(i) A school employee must submit the required forms to their SEBB organization electing their new health plan.

(ii) Any other subscriber must submit the required forms to the SEBB 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 elect a new health plan within the required time period as required in ((~~subsection (1)~~)) (a) or (b) of this ((~~section~~)) subsection will be enrolled in a health plan designated by the director or their designee.

(((~~3~~))) (2) A subscriber must elect a new health plan when their previously selected health 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 ((~~the~~)) their previously selected health plan becomes unavailable.

(((~~a~~))) (b) A school employee must submit the required forms to their ((~~employing agency~~)) SEBB organization electing their new health plan.

(((~~b) A subscriber on continuation coverage~~)) (c) All other subscribers must submit the required forms to the SEBB program electing their new health plan.

(((~~c~~))) (d) The effective date of the change in their 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 the health plan begins on that day.

(((~~4~~))) (e) A subscriber ((~~who fails to elect a new health plan within the required time period as required in subsection (3) of this section~~)) who is enrolled in a high deductible health plan (HDHP) with a health savings account (HSA), will not be eligible to receive contributions to the HSA, and will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(((~~5~~))) (3) A subscriber enrolled in a health plan as described in subsection (((~~2) or (4)~~))) (1)(c) or (2)(e) of this section may not change health plans except as allowed in WAC 182-30-090.

AMENDATORY SECTION (Amending WSR 20-01-082, filed 12/12/19, effective 1/12/20)

WAC 182-30-090 When may a subscriber change health plans? A subscriber may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber may change health plans during the school employees benefits board (SEBB) annual open enrollment period. The subscriber must submit the required enrollment forms to change their health plan. A school employee submits the enrollment forms to their SEBB organization. A subscriber on continuation coverage submits the enrollment forms to the SEBB 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 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~~)) a school employee gaining initial eligibility for SEBB benefits as described in WAC 182-31-040 or regaining eligibility for SEBB benefits as described in WAC 182-30-080. 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. The forms must be received no later than sixty days after the event occurs. A school employee submits the enrollment forms to their SEBB organization. A subscriber on continuation coverage submits the enrollment forms to the SEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or the eligibility certification. 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 the employer contribution toward their employer-based group health plan;

(d) Subscriber has a change in employment from a SEBB organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:

(i) The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or

(ii) The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.

(iii) As used in this subsection the term "public school district" shall be interpreted to not include charter schools and educational service districts.

(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;

Note: As used in (((~~d~~))) (e) of this subsection ((~~special open enrollment~~)) "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(f) 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 available within ((~~50~~)) fifty miles of the subscriber's new ((~~address~~)) residence.

(g) 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);

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

(i) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP;

(j) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare. If the subscriber's current ((~~health~~)) medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's ((~~entitlement to~~)) enrollment in medicare, the subscriber must select a new ((~~health~~)) medical plan as described in WAC 182-30-085(((~~1~~))) (2);

(k) 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 authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(l) 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. The subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the SEBB program determines that a continuity of care issue exists. The SEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period; or

(v) Treatment for a high-risk pregnancy.

(3) If the school employee is having premiums taken from payroll on a pretax basis, a ((~~health~~)) medical 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 20-01-082, filed 12/12/19, effective 1/12/20)

WAC 182-30-100 When may a school 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)? A school employee who is eligible to participate in the salary reduction plan as described in WAC 182-31-060 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 182-31-040 and enrolling as described in WAC 182-30-080(1).

(2) **During annual open enrollment:** An eligible school employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their school employees benefits board (SEBB) organization. An eligible school 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 SEBB organization, the HCA 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: School employees enrolled in a high deductible health plan (HDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. School employees who elect both will only be enrolled in the HDHP with a HSA.

(3) **During a special open enrollment:** A school employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the 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 school employee must submit the required form to their SEBB organization. The SEBB organization 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 school 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.** A school 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) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the school employee;

• Birth, adoption, or when the school 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) School employee's dependent no longer meets SEBB eligibility criteria because:

• School employee has a change in marital status;

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

(iv) School employee has a change in employment status that affects the school employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The school employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution toward 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.

(vi) School employee or a school 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 SEBB annual open enrollment;

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

(viii) School 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 school employee or any other individual to provide insurance coverage for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) School employee or a school employee's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP;

(xii) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare or the school employee or a school employee's dependent loses eligibility for coverage under medicare;

(xiii) School employee or a school employee's dependent's current ((~~health~~)) medical plan becomes unavailable because the school employee or enrolled dependent is no longer eligible for a HSA. The HCA may require evidence that the school employee or a school employee's dependent is no longer eligible for a HSA;

(xiv) School employee or a school employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the school employee or a school employee's dependent. The school employee may not change their health plan election if the school employee's or dependent's physician stops participation with the school employee's health plan unless the SEBB program determines that a continuity of care issue exists. The SEBB program will consider but not limit its consideration to the following:

• Active cancer treatment such as chemotherapy or radiation therapy;

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period; or

• Treatment for a high-risk pregnancy.

(xv) School employee or school employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

(xvi) Subscriber has a change in employment from a SEBB organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available, and the subscriber changes their election. The subscriber may change their election if the change in employment causes:

• The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or

• The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.

• As used in this subsection the term "public school district" shall be interpreted to not include charter schools and educational service districts.

If the ((~~subscriber~~)) school employee is having premiums taken from payroll on a pretax basis, a medical 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 FSA.** A school 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 SEBB organization. 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) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the school employee;

• Birth, adoption, or when the school 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) School employee's dependent no longer meets SEBB eligibility criteria because:

• School employee has a change in marital status;

• School 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) School employee or a school employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by HIPAA;

(iv) School employee or a school employee's dependent has a change in employment status that affects the school employee's or a dependent's eligibility for the medical FSA;

(v) A court order requires the school employee or any other individual to provide insurance coverage for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or CHIP, or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicare.

(c) **DCAP.** A school 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 SEBB organization. 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) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the state registered domestic partner qualifies as a tax dependent of the school employee;

• Birth, adoption, or when the school 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) School employee or a school employee's dependent has a change in employment status that affects the school employee's or a dependent's eligibility for DCAP;

(iii) School employee or school 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 SEBB annual open enrollment;

(iv) School employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) School employee or school 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) School employee's dependent care provider imposes a change in the cost of dependent care; school 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 school employee as defined in IRC 26 U.S.C. Sec. 152.

NEW SECTION

WAC 182-30-140 What is the process for school districts to offer optional benefits? (1) School districts may offer optional benefits that do not compete with any form of the basic or optional benefits offered in the school employees' benefits board (SEBB) program either under the SEBB's authority in RCW 41.05.740 or offered under the health care authority's (HCA) authority in the salary reduction plan authorized in RCW 41.05.300 and 41.05.310. Optional benefits may include:

(a) Emergency transportation;

(b) Identity protection;

(c) Legal aid;

(d) Long-term care insurance;

(e) Noncommercial personal automobile insurance;

(f) Personal homeowner's or renter's insurance;

(g) Pet insurance;

(h) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit regulated by the office of the insurance commissioner;

(i) Travel insurance; and

(j) Voluntary employees' beneficiary association accounts.

(2) Any school districts providing optional benefits must:

(a) Report optional benefits on the form designed and communicated by the HCA; and

(b) Submit the form so it is received by December 1st of each year for the following calendar year as required in RCW 28A.400.280 (2)(b).

(3) The HCA, in consultation with the SEBB will review the optional benefits offered by school districts as described in section 3, chapter 231, Laws of 2020 (HB 2458).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-30-081	School employees benefits board (SEBB) first annual open enrollment.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-020 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 SEBB organization, as well as supplemental accidental death and dismemberment insurance offered to and paid for by school employees for themselves and their dependents.

"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 SEBB medical. School 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.

"Board" means the school employees benefits board established under provisions of RCW 41.05.740.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all state legal 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~~)) SEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconcil-

iation 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 SEBB 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 SEBB 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 SEBB benefits.

"Dependent" means a person who meets eligibility requirements in WAC 182-31-140.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby school employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under 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.

"Employer-based group health plan" means group medical, group vision, and group dental related to a current employment relationship. It does not include medical, vision, 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 HCA by a school employees benefits board (SEBB) organization for its eligible school employees as described under WAC 182-30-130 and 182-31-040.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-31 WAC or WAC 182-30-130, who is enrolled in school employees benefits board (SEBB) benefits, and for whom applicable premium payments have been made.

"Forms" or "form" means both paper forms and forms completed electronically.

"Health plan" means a plan offering medical, vision, dental, or any combination of these coverages, developed by the ((~~SEBB~~)) board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Layoff," for purposes of this chapter, means a change in employment status due to a SEBB ((~~organization~~)) organization's lack of funds or a SEBB organization's organizational change.

"Life insurance" means basic life insurance paid for by the SEBB organization, as well as supplemental life insurance offered to and paid for by school employees for themselves and their dependents.

"Long-term disability insurance" or "LTD insurance" ((~~or "long-term disability insurance"~~)) means any basic long-term disability insurance paid for by the SEBB organization and supplemental long-term disability insurance offered to and paid for by the school employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible school 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 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.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby school 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 employees benefits board" or "PEBB" means the board established under RCW 41.05.055.~~))

"Salary reduction plan" means a benefit plan whereby school employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" means:

• All employees of school districts and charter schools established under chapter 28A.710 RCW;

• Represented employees of educational service districts; and

• Effective January 1, 2024, all employees of educational service districts.

"School employees benefits board organization" or "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.

"School year" means school year as defined in RCW 28A.150.203(11).

"SEBB" means the school employees benefits board ((~~established in RCW 41.05.740~~)).

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

"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 program" means the program within the HCA that administers insurance and other benefits for eligible school employees (as described in WAC 182-31-040 or 182-30-130) and eligible dependents (as described in WAC 182-31-140).

"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, school employees may enroll in or waive enrollment in SEBB medical. School 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 SEBB benefits, see WAC 182-30-090, 182-30-100, 182-31-080, and 182-31-150.

"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 school employee or continuation coverage enrollee who has been determined eligible by the SEBB program or SEBB organizations, is enrolled in SEBB benefits, and is the individual to whom the SEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the school employee in addition to the coverage provided by the school employees benefits board (SEBB) organization.

"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.

"Waive" means an eligible school employee affirmatively declining enrollment in ((~~a SEBB health plan~~)) SEBB medical because the school employee is enrolled in other employer-based group medical, a TRICARE plan((~~s~~)), or medicare as allowed under WAC 182-31-080.

"Week" means a seven-day period starting on Sunday and ending on Saturday.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-030 What are the obligations of a school employees benefits board (SEBB) organization in the application of school employee eligibility? (1) All school employees benefits board (SEBB) organizations must carry out all actions, policies, and guidance issued by the SEBB program which are necessary for the operation of benefit plans, education of school employees, claims administration, and appeals process including those described in chapters 182-30, 182-31, and 182-32 WAC. SEBB organizations must:

(a) Use the methods provided by the SEBB program to determine eligibility and enrollment in benefits;

(b) Provide eligibility determination reports with content and in a format designed and communicated by the SEBB program;

(c) Support SEBB program auditing of eligibility and enrollment decisions as needed; and

(d) Carry out corrective action and pay any penalties imposed by the health care authority (HCA) and established by the ((~~SEBB~~)) board when the SEBB organization's eligibility determinations fail to comply with the criteria under these rules.

(2) SEBB organizations must determine school employee eligibility for SEBB benefits and the employer contribution according to the criteria in WAC 182-31-040 and 182-31-050. SEBB organizations must:

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

(b) Inform a school employee in writing whether or not they are eligible for SEBB benefits upon employment. The written ((~~communication~~)) notice must include information about the school employee's right to appeal eligibility and enrollment decisions. A school employee eligible for SEBB benefits must have no less than ten calendar days after the date of notice to elect coverage;

(c) Routinely monitor all school employees work hours to establish eligibility and maintain the employer contribution toward SEBB benefits ((~~coverage~~));

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

(e) Inform a school employee in writing whether or not they are eligible for SEBB benefits and the employer contribution whenever there is a change in work pattern((~~s~~)) such that the school employee's eligibility status changes. Whenever this occurs, SEBB organizations must inform the school employee of the right to appeal eligibility and enrollment decisions. A school employee eligible for SEBB benefits must have no less than ten calendar days after the date of notice to elect coverage.

(3) SEBB organizations must determine school employee's dependents eligibility for SEBB benefits according to the criteria in WAC 182-31-140.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-050 When does eligibility for the employer contribution for school employees benefits board (SEBB) benefits end? (1) The employer contribution toward school employees benefits board (SEBB) benefits ends the last day of the month in which the school year ends. The employer contribution toward SEBB benefits will end earlier than the end of the school year if one of the following occurs:

(a) The SEBB organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;

(b) The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or

(c) The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

(2) If the SEBB organization deducted the school employee's portion of the premium for SEBB ((~~benefits~~)) insurance coverage from their pay after the school employee was no longer eligible for the employer contribution, SEBB benefits end the last day of the month for which school employee premiums were deducted to prevent a rescission of SEBB benefits. The SEBB organization must refund any premiums deducted for the school employee's portion of the premium that were deducted in advance of any month's coverage for which the school employee is no longer eligible for the employer contribution.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-070 Is dual enrollment in school employees benefits board (SEBB) prohibited? School employees benefits board (SEBB) ((~~health plan~~)) medical, dental, and vision coverage is limited to a single enrollment per individual.

(1) An individual who has more than one source of eligibility for enrollment in SEBB ((~~health plan~~)) medical, dental, and vision coverage (called "dual eligibility") is limited to one enrollment.

(2) An eligible school employee may waive SEBB medical and enroll as a dependent under the ((~~health~~)) medical plan of their spouse, state registered domestic partner, or parent as described in WAC 182-31-080.

(3) A dependent enrolled in ((~~a SEBB health plan~~)) SEBB medical, dental, or vision who becomes eligible for SEBB benefits as a school employee must elect to enroll in SEBB benefits as described in WAC 182-30-080(1). This includes making an election to enroll in or waive enrollment in SEBB medical as described in WAC 182-31-080 (1)(a).

(a) If the school employee does not waive enrollment in SEBB medical, the school employee is not eligible to remain enrolled in their spouse's, state registered domestic partner's, or parent's SEBB medical as a dependent. If the school employee's spouse, state registered domestic partner, or parent does not remove the school employee (who is enrolled as a dependent) from their subscriber account, the SEBB program will terminate the school employee's enrollment as a dependent the last day of the month before the school employee's enrollment in SEBB benefits begins as described in WAC 182-31-040.

Exception: An enrolled dependent who becomes newly eligible, at the start of the school year, for SEBB benefits as a school employee could be dual-enrolled in SEBB ((~~coverage~~)) medical, dental, and vision for one month. This exception is only allowed for the first month the dependent is enrolled as a school employee.

(b) If the school employee elects to waive their enrollment in SEBB medical, the school employee will remain enrolled in SEBB medical under their spouse's, state registered domestic partner's, or parent's SEBB ((~~health plan~~)) medical as a dependent.

(4) A child who is eligible for medical, dental, and vision under two subscribers may be enrolled ((~~as a dependent under the health plan of only one~~)) under both subscribers but is limited to a single enrollment in SEBB medical, a single enrollment in SEBB dental, and a single enrollment in SEBB vision.

(5) When a school employee is eligible for the employer contribution toward((~~s~~)) SEBB benefits due to employment in more than one SEBB organization the following provisions apply:

(a) When a school employee is eligible for the employer contribution during a school year under WAC 182-31-040 and 182-30-130 the SEBB organization that has determined the school employee eligible under WAC 182-31-040 must make the employer contribution;

(b) If the school employee is eligible for the employer contribution under WAC 182-31-040 at two different SEBB organizations, the school employee must choose to enroll under only one SEBB organization;

(c) If the school employee is eligible for the employer contribution under WAC 182-30-130 at two different SEBB organizations, the school employee must choose to enroll under only one SEBB organization;

(d) If the school employee loses eligibility under one SEBB organization, they ((~~may choose to enroll in the other SEBB organization they were eligible for the employer contribution at. The school employee~~)) must notify their other SEBB organization ((~~they were eligible for the employer contribution at~~)) no later than sixty days from the date of loss of the first SEBB ((~~coverage~~)) benefits in order to transfer coverage;

(e) The school employee's elections remain the same when a school employee transfers their enrollment under one SEBB organization to another SEBB organization without a break in SEBB benefits for one month or more, as described in (d) of this subsection.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-080 When may a school employee waive enrollment in school employees benefits board (SEBB) medical and when may they enroll in SEBB medical after having waived enrollment? A school employee may waive enrollment in school employees benefits board (SEBB) 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 a school employee gaining initial eligibility for SEBB benefits. A school employee who waives enrollment in SEBB medical must enroll in dental, vision, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability insurance.

(1) To waive enrollment in SEBB medical, the school employee must submit the required form to their SEBB organization at one of the following times:

(a) **When the school employee becomes eligible:** A school employee may waive SEBB medical when they become eligible for SEBB benefits. The school employee must indicate their election to waive enrollment in SEBB medical on the required form and submit the form to their SEBB organization. The SEBB organization must receive the form no later than thirty-one days after the date the school employee becomes eligible for SEBB benefits (see WAC 182-30-080). SEBB medical will be waived as of the date the school employee becomes eligible for SEBB benefits.

(b) **During the annual open enrollment:** A school employee may waive SEBB medical during the annual open enrollment. The required form must be received by the school employee's SEBB organization before the end of the annual open enrollment. SEBB medical will be waived beginning January 1st of the following year.

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

The school employee must submit the required form to their SEBB organization. The SEBB organization 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 school employee must provide evidence of the event that creates the special open enrollment to their SEBB organization.

SEBB 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, SEBB 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, SEBB medical will be waived the last day of the previous month.

(2) If a school employee waives SEBB medical, the school employee may not enroll dependents in SEBB medical.

(3) Once SEBB medical is waived, the school employee is only allowed to enroll in SEBB medical at the following times:

(a) During the annual open enrollment. The required form must be received by the school employee's SEBB organization before the end of the annual open enrollment. SEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows a school 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 school employee must submit the required form to their SEBB organization. The SEBB organization 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 school employee must provide evidence of the event that creates the special open enrollment to the SEBB organization.

SEBB 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, SEBB medical for the school employee will begin ((~~for a school employee~~)) on the first day of the month in which the event occurs ((~~(see WAC 182-31-150(3)) for the~~)). SEBB medical ((~~effective date of a~~)) for the newly born child, newly adopted child, spouse, or state-registered domestic partner((~~,~~)) will begin as described in WAC 182-31-150 (3)(a)(iv).

(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 school employee, the school employee's dependent, or both.

(a) School employee acquires a new dependent due to:

(i) Marriage or registering ((~~for~~)) a state registered domestic partnership;

(ii) Birth, adoption, or when the school employee 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) School employee or a school 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) School employee has a change in employment status that affects the school employee's eligibility for their employer contribution toward their employer-based group medical;

(d) The school 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;

Note: 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) School employee or a school 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 SEBB program's annual open enrollment;

(f) School 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 results in the dependent losing their health insurance;

(g) A court order requires the school employee or any other individual to provide a health plan for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(h) School employee or a school employee's dependent ((~~becomes entitled to~~)) enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

Note: A school employee may only return from having waived SEBB medical for the events described in (h) of this subsection. A school employee may not waive their SEBB medical for the events described in (h) of this subsection.

(i) School employee or a school employee's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or ((~~a state children's health insurance program (CHIP)~~)) CHIP;

(j) School employee or a school employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;

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

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-090 When is an enrollee eligible to continue school employees benefits board (SEBB) benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) A school employee or a school employee's dependent who loses eligibility for the employer contribution toward school employees benefits board (SEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for all or any combination of SEBB medical, dental, or vision.

(2) A school employee or a school employee's dependent may continue SEBB ((~~health plan coverage~~)) medical, dental, or vision 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 SEBB policy resolution SEBB 2018-01 a subscriber's state registered domestic partner and the state registered domestic partner's children may continue SEBB benefits on the same terms and conditions as a legal spouse or child under COBRA.~~))

(a) The election must be received by the SEBB program no later than sixty days from the date the school employee's or school employee's dependent's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB 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 182-30-040 (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 182-31-040. 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 SEBB 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) A school employee enrolled in a medical flexible spending arrangement (FSA) and the school 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 school 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 SEBB 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.

(3) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue SEBB medical, dental, or vision on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(4) Medical, dental, and vision coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for the employer contribution as described in WAC 182-31-050.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-100 What options for continuation coverage are available to school employees and their dependents during certain types of leave or when employment ends due to a layoff? School employees who have established eligibility for school employees benefits board (SEBB) benefits as described in WAC 182-31-040 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

(1) School employees who are no longer eligible for the employer contribution toward SEBB benefits due to an event described in (b)(i) through (v) of this subsection may continue ((~~SEBB benefits~~)) coverage 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) School employees may continue any combination of medical, dental, or vision, and may also continue life insurance((,)) and accidental death and dismemberment (AD&D) insurance. If life insurance or AD&D insurance is elected, both basic life and basic AD&D insurance must be continued. School employees who continue basic life insurance and basic AD&D insurance may also continue supplemental life and AD&D insurance;

(b) School employees in the following circumstances who lose their eligibility for the employer contribution toward SEBB benefits qualify to continue coverage under this subsection:

(i) School employees who are on authorized leave without pay;

(ii) School employees who are receiving time-loss benefits under workers' compensation;

(iii) School employees who are called to active duty in the uniformed services as defined under USERRA;

(iv) School employees whose employment ends due to a layoff as defined in WAC 182-31-020; and

(v) School employees who are applying for disability retirement.

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

(d) School employees may self-pay for a maximum of twenty-nine months. The school employee's first premium payment and applicable premium surcharges are due 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 SEBB medical, must be made to the HCA as well as premiums associated with continuing SEBB dental and vision insurance coverage. Premiums associated with continuing life insurance coverage or AD&D insurance coverage must be made to the contracted vendor. Following the school employee's first premium payment, the school employee must pay the premium amounts for SEBB ((~~benefits~~)) insurance coverage and applicable premium surcharges as premiums become due; and

(e) If the school employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the school employee's SEBB ((~~benefits~~)) insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-30-040 (1)(((~~b~~))) (c).

(2) The number of months that school 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). School 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, vision, or any combination of them for the remaining difference in months by self-paying the premium and applicable premium surcharges as described in WAC 182-31-090.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-110 What options are available if a school employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program? (1) A school 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 school employees benefits board (SEBB) ((~~insurance coverage~~)) benefits in accordance with the federal FMLA ((~~or RCW 50A.04.245~~)). The school employee may also continue current supplemental life, supplemental accidental death and dismemberment (AD&D), and supplemental long-term disability (LTD) insurance. The school employee's SEBB organization is responsible for determining if the school employee is eligible for leave under FMLA and the duration of such leave. ((~~The employment security department is responsible for determining if the school employee is eligible for leave under the paid family and medical leave program.~~

~~(2) If a school employee's monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, the school employee's SEBB benefits will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.~~))

(2) A school employee on approved leave under the paid family and medical leave program under chapter 50A.05 RCW may continue to receive the employer contribution toward SEBB benefits in accordance with RCW 50A.35.020. The school employee may also continue current supplemental life, supplemental AD&D, and supplemental LTD insurance. The employment security department is responsible for determining if the school employee is eligible for the paid family and medical leave program.

(3) If a school employee exhausts the period of leave approved under FMLA or paid family and medical leave, SEBB benefits may be continued by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the SEBB organization, as described in WAC 182-31-100(1).

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-120 What options for continuation coverage are available to school employees during their appeal of a grievance? (1) A school employee awaiting the hearing outcome of a grievance action before any of the following may continue their school employees benefits board (SEBB) insurance coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the SEBB organization,

on the same terms as a school employee who is granted leave as described in WAC 182-31-100(1):

(a) An arbitrator; ((~~or~~))

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

(c) A court.

(2) The school employee must pay premium amounts and applicable premium surcharges associated with SEBB ((~~benefits~~)) 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, SEBB ((~~benefits~~)) insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-30-040 (1)(((~~(b)~~))) (c).

(3) If the dismissal is upheld, all SEBB ((~~benefits~~)) insurance coverage will ((~~end~~)) terminate 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 school employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the school employee may continue SEBB medical, dental, vision, or any combination of them for the remaining months available under COBRA. See WAC 182-31-090 for information on COBRA. The number of months the school employee self-paid premiums during the appeal will count toward the total number of months allowed under COBRA.

(5) If the arbitrator, committee, or court sustains the school employee in the appeal and directs reinstatement of SEBB organization paid SEBB ((~~benefits~~)) insurance coverage retroactively, the SEBB organization must forward to HCA the full employer contribution for the period directed by the arbitrator, committee, or court and collect from the school employee the school employee's share of premiums due, if any.

(a) When the employer contribution is reinstated, HCA will refund premiums and applicable premium surcharges the school employee paid only if the school employee retroactively pays their employee contribution amounts for SEBB benefits. In the alternative, at the request of the school employee, HCA may deduct the school employee's contribution amount for SEBB ((~~insurance coverage~~)) benefits from the refund of premiums and applicable premium surcharges self-paid by the school employee during the appeal period.

(b) All supplemental life insurance((~~,~~)) and supplemental accidental death and dismemberment (AD&D) insurance that was in force at the time of dismissal shall be reinstated retroactively only if the school employee makes retroactive payment of premium for any such supplemental coverage that was not continued by self-payment during the appeal process. If the school employee chooses not to pay the retroactive premium, evidence of insurability will be required to ((~~restore~~)) enroll in such supplemental coverage.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-130 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-31-140 or 182-30-130? If eligible, dependents may continue ((~~SEBB benefits~~)) 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 school employees benefits board (SEBB) organization, following their loss of eligibility under the subscriber's ((~~SEBB benefits~~)) health plan coverage. The dependent's first premium payment and applicable premium surcharges are due ((~~to the HCA~~)) no later than forty-five days after the dependent's election ((~~is received by the SEBB program~~)) period ends as described in WAC 182-31-090 or 182-12-265, whichever applies. Premiums and applicable premium surcharges associated with continuing SEBB medical, must be made to the HCA as well as premiums associated with continuing SEBB dental or SEBB vision insurance coverage. Following the dependent's first premium payment, the dependent must pay premium and applicable premium ((~~surcharge amounts associated with SEBB benefits as premiums and applicable premium~~)) surcharges as they become due. If the monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, SEBB ((~~benefits~~)) insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid as described in WAC 182-30-040 (1)(((~~(b)~~))) (c). The SEBB program must receive the required forms as outlined in the SEBB initial notice of COBRA and continuation coverage rights. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Dependents who lose eligibility due to the death of ((~~an~~)) a school employee may be eligible to continue health plan enrollment as described in WAC ((~~182-12-180 or~~)) 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-31-140 are eligible to continue SEBB ((~~benefits enrollment~~)) medical, dental, or vision under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-31-090 for more information on COBRA.

(3) A subscriber's state registered domestic partner and the state registered domestic partner's children may continue SEBB medical, dental, or vision on the same terms and conditions as spouses and other eligible dependents under COBRA as described under RCW 26.60.015.

(4) No continuation coverage will be offered unless the SEBB program is notified through hand delivery or United States Postal Service mail of the qualifying event as outlined in the SEBB initial notice of COBRA and continuation coverage rights.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-135 Where may school employee survivors go for additional coverage options? A school employee's spouse, state registered domestic partner, or child who loses eligibility for the employer contribution toward school employees benefits board (SEBB) ((~~insurance~~)) benefits due to the death of an eligible school employee may be eligible to enroll in or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage as described in WAC 182-12-265 rather than enrolling in continuation coverage.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-140 Who are eligible dependents? To be enrolled in SEBB ((~~benefits~~)) health plan coverage, a dependent must be eligible under this section and the subscriber must comply with enrollment procedures outlined in WAC 182-31-150.

The school employees benefits board (SEBB) program verifies the eligibility of all dependents and will request documents from subscribers that provide evidence of a dependent's eligibility. The SEBB program reserves the right to review a dependent's eligibility at any time. The SEBB program will remove a subscriber's enrolled dependents from health plan ((~~enrollment~~)) coverage if the SEBB program is unable to verify a dependent's eligibility. ((~~The SEBB program and SEBB organizations~~)) A dependent will not ((~~enroll dependents into SEBB benefits if they are~~)) be enrolled in SEBB health plan coverage if the SEBB program or the SEBB organization is unable to verify ((~~a~~)) the dependent's eligibility within the SEBB program enrollment timelines.

The subscriber must provide notice, in writing, when their dependent is not eligible under this section as described in WAC 182-31-150 (2)(a). ((~~A school employee must notify their SEBB organization, except as required in subsection (3)(h)(ii) of this section. A subscriber on continuation coverage must notify the SEBB program. The notification must be received no later than sixty days after the date their dependent is no longer eligible under this section. See WAC 182-31-150(2) for the consequences of not removing an ineligible dependent from SEBB benefits.~~))

The following are eligible as dependents:

(1) Legal spouse. A former spouse is not an eligible dependent 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. A former state registered domestic partner is not an eligible dependent 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 (f) 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 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 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;

(d) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(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;

(f) 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 notify the SEBB 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 182-31-150 (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 if they later become incapable of self-support; and

(v) The SEBB 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~~)). Verification will require renewed proof of disability and dependence from the subscriber.

(g) Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the 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.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-150 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in school employees benefits board (SEBB) ((~~benefits~~)) health plan coverage and the effective date of supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled ((~~in a medical plan~~)) to enroll their dependent. 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 SEBB benefits. If eligibility is verified ((~~and the dependent is enrolled,~~)) the dependent's effective date will be as follows:

(i) SEBB health plan coverage will be the same as the subscriber's effective date((~~, except if the subscriber enrolls a newborn child in supplemental dependent life insurance. The newborn child's dependent life insurance coverage or AD&D insurance will be effective on the date the child becomes fourteen days old~~));

(ii) Supplemental dependent life or AD&D insurance, if elected, will be effective the first day of the month following the date the contracted vendor receives the required form or approves the enrollment. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage is effective.

(b) **During the annual open enrollment.** SEBB ((~~benefits~~)) 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((~~s (3) and (5)(f)~~)) (3) of this section;

(d) **When a National Medical Support Notice (NMSN)** requires a subscriber to cover a dependent child as described in WAC 182-31-160; or

(e) **Any time during the calendar year for supplemental dependent life insurance or AD&D insurance** by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

(2) **Removing dependents from ((~~a subscriber's~~)) SEBB health plan coverage or supplemental dependent life insurance or AD&D insurance.**

(a) **A dependent's eligibility for enrollment in SEBB health plan coverage or supplemental dependent life insurance or AD&D insurance ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-31-140. Subscribers must provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of dependent ceasing to be eligible as a dependent child as described in WAC 182-31-140(3). The notice must be received within sixty days of the last day of the month the dependent loses eligibility for SEBB health plan coverage. School employees must notify their SEBB organization when a dependent is no longer eligible except as required under WAC 182-31-140 (3)(f)(ii). All other subscribers must notify the SEBB program. 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~~)) SEBB medical, dental, or vision under one of the continuation coverage options described in WAC 182-31-130;

(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 182-31-130;

(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) **School employees have the opportunity to remove eligible dependents:**

(i) During the annual open enrollment. The dependent will be removed from SEBB health plan coverage the last day of December; ((~~or~~))

(ii) During a special open enrollment as described in subsections (3) and ((~~(5)~~)) (4)(f) of this section;

(iii) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in SEBB coverage, and that health plan coverage is in fact provided as described in WAC 182-31-160(2); or

(iv) Any time during the calendar year from supplemental dependent life or AD&D insurance by submitting the required form to the contracted vendor.

(c) **Enrollees with SEBB continuation coverage as described in WAC 182-31-090 and 182-31-100 may remove dependents** from their SEBB ((~~benefits~~)) health plan coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the SEBB program. The dependent will be removed from the subscriber's SEBB ((~~benefits~~)) health plan coverage prospectively. SEBB ((~~benefits~~)) health plan coverage will end on the last day of the month in which the written notice is received by the SEBB 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, SEBB health plan coverage will end on the last day of the previous month. SEBB continuation coverage enrollees may remove supplemental dependent life or AD&D insurance any time during the calendar year by submitting the required form to the contracted vendor.

(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 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) SEBB ((~~benefits~~)) health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

(ii) ((~~Enrollment of~~)) SEBB health plan coverage for an extended dependent or a dependent with a disability will ((~~be~~)) begin the first day of the month following the later of the event date ((~~as described in WAC 182-31-140(3)~~)) or eligibility certification.

(iii) The dependent will be removed from the subscriber's SEBB ((~~benefits~~)) 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, SEBB ((~~benefits~~)) health plan coverage will begin or end as follows:

• For the newly born child, SEBB ((~~benefits~~)) health plan coverage will begin the date of birth;

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

• For a spouse or state registered domestic partner of a subscriber, SEBB health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from SEBB 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 supplemental dependent life insurance coverage or accidental death and dismemberment insurance purchased by the employee becomes effective~~)).

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

(((~~b~~))) (i) Subscriber acquires a new dependent due to:

(((~~i~~))) • Marriage or registering 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~~))) (ii) 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~~))) (iii) 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~~))) (iv) 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;

Note: As used in (((~~e~~))) (iv) 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~~))) (v) 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 SEBB program's annual open enrollment;

(((~~g~~))) (vi) 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 results in the dependent losing their health insurance;

(((~~h~~))) (vii) 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~~))) (viii) Subscriber or a subscriber's dependent ((~~becomes entitled to~~)) enrolls in 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~~))) (ix) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP.

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** For SEBB health plan coverage, a school employee must submit the required forms to their SEBB organization, a subscriber on continuation coverage must submit the required forms to the SEBB 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 school employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval within the required time frames.

(a) If a subscriber wants to enroll their eligible dependents in SEBB health plan coverage or supplemental dependent life or AD&D insurance when the subscriber becomes eligible to enroll in SEBB benefits, the subscriber must include the dependent's enrollment information on the required forms and submit them within the required time frame as described in WAC 182-30-060 and 182-30-080.

(b) If a subscriber wants to enroll eligible dependents in SEBB health plan coverage during the SEBB 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. A school employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. A school employee may enroll a dependent in supplemental life insurance up to the guaranteed issue coverage amount without evidence of insurability if the required form is submitted to the contracted ven-

dor as required. Evidence of insurability will be required for supplemental dependent life insurance over the guaranteed issue coverage amount. Evidence of insurability is not required for supplemental AD&D insurance.

(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 in SEBB health plan coverage, the subscriber should notify the SEBB 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 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. A school employee enrolling a dependent in supplemental life insurance or AD&D insurance must submit the required form to the contracted vendor for approval. A newly born child must be at least fourteen days old before supplemental dependent life insurance or AD&D insurance coverage can become effective.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability in SEBB health plan coverage, 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 182-31-140 (3)~~)) (a), (b), and (f) of this subsection. To recertify an enrolled child with a disability, the required forms must be received by the SEBB program or the contracted vendor by the child's scheduled SEBB health plan coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status in SEBB health plan coverage 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.

(g) A school employee may enroll a dependent in supplemental life insurance or AD&D insurance at any time during the calendar year by submitting the required form to the contracted vendor for approval. Evidence of insurability may be required for supplemental dependent life insurance but will not be required for supplemental AD&D insurance.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-160 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:

(a) The subscriber may enroll their dependent child and request changes to their health plan coverage as described under (c) of this subsection. School employees submit the required forms to their school employees benefits board (SEBB) organization. Subscribers on continuation coverage submit the required forms to the SEBB program;

(b) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the SEBB organization or the SEBB program may make enrollment or health plan coverage changes according to (c) of this subsection upon request of:

(i) The child's other parent; or

(ii) Child support enforcement program.

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

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

(ii) A school employee who has waived SEBB medical as described in WAC 182-31-080 will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;

(iii) The subscriber's selected health plan will be changed if directed by the NMSN;

(iv) If the dependent is already enrolled under another SEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN; 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.

(d) Changes to health plan coverage or enrollment as described in (c)(i) through (iii) of this subsection will begin the first day of the month following receipt by the SEBB organization of the NMSN. If the NMSN is received by the SEBB organization 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 (c)(iv) of this 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.

(2) When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in SEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's SEBB ((~~insurance~~)) health plan coverage prospectively.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-31-190 School employees benefits board (SEBB) wellness incentive program eligibility and procedural requirements. The ((~~school employees benefits board (SEBB)~~)) board annually determines the design of the SEBB wellness incentive program.

(1) All subscribers are eligible to participate in the SEBB wellness incentive program.

(2) ((~~For plan year 2020, all subscribers that register in SmartHealth and complete the well-being assessment during the 2019 open enrollment will earn a $50 incentive as a reduction in their SEBB medical deductible or a deposit into their SEBB health savings account (HSA).~~

~~(3)~~)) Effective January 1, 2020, to receive the SEBB 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 SEBB wellness incentive program requirements during the current plan year by the following deadline:

(a) For subscribers continuing enrollment in SEBB medical and subscribers enrolling in SEBB medical with an effective date in January through September, the deadline is November 30th; or

(b) For subscribers enrolling in SEBB medical with an effective date in October through December, the deadline is December 31st.

(((~~(4)~~))) (3) Subscribers who do not complete the requirements according to subsection (((~~(3)~~))) (2) of this section within the time frame described are not eligible to receive a SEBB 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 ((~~SEBB 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.

(((~~(5)~~))) (4) A SEBB wellness incentive will be provided only if:

(a) For the wellness incentive described in subsection (((~~(3)~~))) (2) of this section the subscriber is still eligible for the SEBB wellness incentive program and is enrolled in a SEBB medical plan in the year the incentive applies;

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

(c) Specific appropriations are provided for wellness incentives.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-31-091	School employees benefits boards (SEBB) continuation coverage for school employees and their dependents who are not eligible for SEBB benefits as of January 1, 2020, and for dependents who were already on a SEBB organization's continuation coverage as of December 31, 2019?

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-010 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 school employees benefits board (((~~SEBB~~))) program.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-020 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 SEBB organization((~~s~~)), as well as supplemental accidental death and dismemberment insurance offered to and paid for by school employees for themselves and their dependents.

"Appellant" means a person who requests a brief adjudicative proceeding with the SEBB appeals unit about the action of the SEBB organization, the HCA, or its contracted vendor.

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

"Board" means the school employees benefits board established under provisions of RCW 41.05.740.

"Brief adjudicative proceeding" means the process described in RCW 34.05.482 through 34.05.494 and in WAC 182-32-2000 through 182-32-2160.

"Business days" means all days except Saturdays, Sundays, and all state legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays, Sundays, and all state legal 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 SEBB 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 SEBB benefits.

"Denial" or "denial notice" means an action by, or communication from, a school employees benefits board (SEBB) organization, contracted vendor, or the SEBB program that aggrieves a subscriber, a dependent, or an applicant, with regard to SEBB 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 182-31-140.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby school employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under 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.

"Disability insurance" includes any basic long-term disability insurance paid for by the school employees benefits board (SEBB) organization and any supplemental long-term disability or supplemental short-term disability paid for by the school employee.

"Dispositive motion" is 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.

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

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-31 WAC or WAC 182-30-130, who is enrolled in SEBB 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 ((~~health care~~)) authority or its designee.

"Final order" means an order that is the final 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 182-32-3000 through 182-32-3200.

"HCA hearing representative" means a person who is authorized to represent the SEBB 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, vision, dental, or any combination of these coverages, developed by the ((~~SEBB~~)) board 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.

"Life insurance" means any basic life insurance paid for by the SEBB organization, as well as supplemental life insurance offered to and paid for by school employees for themselves and their dependents.

"Long-term disability insurance" or "LTD insurance" ((~~or "long-term disability insurance" includes~~)) means basic long-term disability insurance paid for by the SEBB organization and supplemental long-term disability insurance offered to and paid for by the school employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible school 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 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.

"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 school 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 employees benefits board" or "PEBB" means the board established under provisions of RCW 41.05.055.~~))

"Review officer or officers" means one or more delegates from the director that consider appeals relating to the administration of SEBB benefits by the SEBB program.

"Salary reduction plan" means a benefit plan whereby school 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" means:

• All employees of school districts and charter schools established under chapter 28A.710 RCW;

• Represented employees of educational service districts; and

• Effective January 1, 2024, all employees of educational service districts.

"School employees benefits board organization" or "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 benefit board.

"SEBB" means the school employees benefits board ((~~established in RCW 41.05.740~~)).

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

"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 program" means the program within the HCA that administers insurance and other benefits for eligible school employees (as described in WAC 182-31-040 or 182-30-130), and eligible dependents (as described in WAC 182-31-140).

"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 school employee or continuation coverage enrollee who has been determined eligible by the SEBB program or SEBB organizations, is enrolled in SEBB benefits, and is the individual to whom the SEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee.

"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.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-058 Service or serve. (1) When the rules in this chapter or in other school employees benefits board (SEBB) program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives as described in this chapter. In this section, requirements for service or delivery by a party apply also when service is required by the presiding officer or review officer or officers, or hearing officer.

(2) Unless otherwise stated in applicable law, documents may be sent only as identified in this chapter to accomplish service. A party may serve someone by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail sent via the United States Postal Service or Washington state consolidated mail services;

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document with the presiding officer, review officer or officers, or hearing officer's office, or when required by law.

(4) Service is complete when:

(a) Personal service is made;

(b) Mail is properly stamped, addressed, and deposited in the United States Postal Service;

(c) Mail is properly addressed, and deposited in the Washington state consolidated mail services;

(d) Fax produces proof of transmission;

(e) A parcel is delivered to a commercial delivery service with charges prepaid; or

(f) A parcel is delivered to a legal messenger service with charges prepaid.

(5) A party may prove service by providing any of the following:

(a) A signed affidavit of mailing or certificate of ((~~mailing~~)) service;

(b) The certified mail receipt signed by the person who received the parcel;

(c) A signed receipt from the person who accepted the commercial delivery service or legal messenger service parcel;

(d) Proof of fax transmission.

(6) Service cannot be made by electronic mail unless mutually agreed to in advance and in writing by the parties.

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-32-3130.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-066 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 ((~~degree or level of proof~~)) 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 hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and school employees benefits board (SEBB) organizations 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 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-120 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 Friday and the party has twenty-one days to request a review, start counting the days with Saturday.)

(2) 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 ten days or less, intermediate Saturdays, Sundays and state legal holidays ((~~shall~~)) must 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 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-130 Index of significant decisions. (1) A final ((~~decision~~)) order 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) website. As decisions are indexed they will be available on the website.

(3) A final ((~~decision~~)) order 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~~)) order; or

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

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2010 Appealing a decision regarding school employees benefits board (SEBB) eligibility, enrollment, premium payments, premium surcharges, a wellness incentive, or the administration of benefits. (1) Any current or former school employee of a school employees benefits board (SEBB) organization or their dependent aggrieved by a decision made by the SEBB organization with regard to SEBB eligibility, enrollment, or premium surcharges may appeal that decision to the SEBB organization by the process described in WAC 182-32-2020.

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

(2) Any subscriber or dependent aggrieved by a decision made by the SEBB program with regard to SEBB eligibility, enrollment, premium payments, ((~~or~~)) premium surcharges, eligibility to participate in the SEBB wellness incentive program, or eligibility to receive the SEBB wellness incentive, may appeal that decision to the SEBB appeals unit by the process described in WAC 182-32-2030.

(3) Any enrollee aggrieved by a decision regarding the administration of ((~~a health plan~~)) SEBB medical, dental, and vision, life insurance, accidental death and dismemberment (AD&D) insurance, or 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.

(4) Any SEBB enrollee aggrieved by a decision regarding the administration of SEBB property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(5) Any school employee aggrieved by a decision regarding the administration of a benefit offered under the salary reduction plan may appeal that decision by the process described in WAC 182-32-2050.

(6) Any subscriber aggrieved by a decision made by the SEBB wellness incentive program contracted vendor regarding the completion of the SEBB 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 182-32-2040.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2020 Appealing a decision made by a school employees benefits board (SEBB) organization about eligibility, premium surcharges, or enrollment in benefits. (1) An eligibility, premium surcharges, or enrollment decision made by a school employees benefits board (SEBB) organization may be appealed by submitting a written request for administrative review to the SEBB organization. The SEBB organization 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 182-32-2070.

(a) Upon receiving the request for administrative review, the SEBB organization 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 SEBB organization must render a written decision within thirty days of receiving the written request for administrative review. The written decision must be sent to the school employee or school employee's dependent who submitted the request for administrative review and must include a description of the appeal rights. The SEBB organization must also send a copy of the SEBB organization's written decision to the SEBB organization's administrator (or designee) and to the SEBB appeals unit. If the SEBB organization 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 ((~~thirtieth~~)) thirty-first day and the original underlying SEBB organization decision may be appealed to the SEBB appeals unit by following the process in this section.

(c) The SEBB organization may reverse eligibility, premium surcharges, or enrollment decisions as permitted by WAC 182-30-060.

(2) Any current or former school employee or school employee's dependent who disagrees with the SEBB organization'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 SEBB appeals unit.

(a) The SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the SEBB organization's written decision on the request for administrative review. If the SEBB organization fails to render a written decision within thirty days of receiv-

ing a written request for administrative review, the SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(i) The SEBB appeals unit must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the SEBB appeals unit receives a request for a brief adjudicative proceeding, the SEBB appeals unit will send a request for documentation and information to the applicable SEBB organization. The SEBB organization will then have two business days to respond to the request and provide the requested documentation and information. The SEBB organization will also send a copy of the documentation and information to the appellant.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If a school employee fails to timely request a brief adjudicative proceeding ((~~to appeal the SEBB organization's written decision within thirty days by following the process in subsection (2) of this section~~)), the SEBB organization's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2030 Appealing a school employees benefits board (SEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, and a SEBB wellness incentive. (1) A decision made by the school employees benefits board (SEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, or a SEBB wellness incentive may be appealed by submitting a request to the SEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(2) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(3) The request for a brief adjudicative proceeding from a current or former school employee or school employee's dependent must be received by the SEBB appeals unit no later than thirty days after the date of the denial notice.

(4) The request for a brief adjudicative proceeding from a self-pay enrollee or dependent of self-pay enrollee must be received by the SEBB appeals unit no later than sixty days after the date of the denial notice.

(5) The SEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(6) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(7) Failing to timely request a brief adjudicative proceeding ((~~to appeal a decision made under this section within applicable time frames described in subsections (3) and (4) of this section,~~)) will result in the prior SEBB program decision becoming the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2040 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 school employees benefits board (SEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the SEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the SEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former school employee must be received by the SEBB 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 182-32-2070.

(b) The request for a brief adjudicative proceeding from a self-pay subscriber must be received by the SEBB 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 182-32-2070.

(3) The SEBB 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 182-32-2020(2)~~)), the decision of the SEBB wellness incentive program contracted vendor becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2050 How can a school employee appeal a decision regarding the administration of benefits offered under the salary reduction plan? (1) Any school employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the salary reduction plan may appeal that decision by submitting a written request for administrative review to their school employees benefits board (SEBB) organization. The SEBB organization must receive the written request for administrative review no later than thirty days after the date of the decision resulting in denial. The contents of the written request for administrative review are to be provided as described in WAC 182-32-2070.

(a) Upon receiving the written request for administrative review, the SEBB organization ((~~shall~~)) must perform a com-

plete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The SEBB organization ((~~shall~~)) must render a written decision within thirty days of receiving the written request for administrative review. The written decision ((~~shall~~)) must be sent to the school employee who submitted the written request for review and must include a description of appeal rights. The SEBB organization ((~~shall~~)) must also send a copy of the SEBB organization's written decision to the SEBB organization's administrator (or designee) and to the SEBB appeals unit. If the SEBB organization 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 ((~~thirtieth~~)) thirty-first day and the original underlying SEBB organization decision may be appealed to the SEBB appeals unit by following the process in this section.

(2) Any school employee who disagrees with the SEBB organization'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 SEBB appeals unit.

(a) The SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the SEBB organization's written decision on the request for administrative review. If a SEBB organization fails to render a written decision within thirty days of receiving a written request for administrative review, the SEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date the request for administrative review was deemed denied. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-32-2070.

(i) The SEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the SEBB appeals unit receives a request for a brief adjudicative proceeding, the SEBB appeals unit will send a request for documentation and information to the applicable SEBB organization. The SEBB organization will then have two business days to respond to the request and provide the documentation and information requested. The SEBB organization will also send a copy of the documentation and information to the school employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If a school 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 SEBB organization's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

(3) Any school 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 salary reduction plan may appeal that decision to the ((~~HCA~~)) authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any school 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 salary reduction plan may request a brief adjudicative proceeding by submitting a written request to the SEBB appeals unit. The SEBB 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 182-32-2070.

(i) The SEBB 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 a school 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 ((~~health care authority (HCA) final decision~~)) authority's final order without further action.

(4) Any school employee aggrieved by a decision regarding the administration of the premium payment plan offered under the salary reduction plan may request a brief adjudicative proceeding to be conducted by the ((~~HCA~~)) authority by submitting a written request to the SEBB appeals unit for a brief adjudicative proceeding.

(a) The SEBB 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 SEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The SEBB 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 a school 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 SEBB program's prior written decision becomes the authority's final ((~~decision~~)) order without further action.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2085 Continuances. The presiding officer, review officer or officers may grant, in their sole discretion, a request for a continuance on motion of the appellant, the authority, or on their own ((~~motion~~)). The continuance may be up to thirty calendar days.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-2090 Initial order. Unless a continuance has been granted, within ten days after the school employees benefits board (SEBB) appeals unit receives a request for a brief adjudicative proceeding, the presiding officer ((~~shall~~)) must 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 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2100 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 a school employees benefits board (SEBB) organization decision, SEBB program decision, or a decision made by a SEBB 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 make an oral request for review of the initial order with the SEBB 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 initial order becomes the authority's final order without 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 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 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-2110 Final order. (1) A final order issued by the review officer or officers will be ((~~issued~~)) in writing and include a brief statement of the reasons for the decision.

(2) The final order must be ((~~rendered and~~)) served within twenty days of the date of the initial order or of the date the request for review of the initial order was received by the SEBB appeals unit, whichever is later.

(3) The final order will include a notice that reconsideration and judicial review may be available.

(4) A request for review of the initial order is deemed denied if the authority does not issue a final order within twenty days after the request for review of the initial order is filed.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2120 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; and

(c) Within five business days of receiving a request for reconsideration, the review officer or officers 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 review officer or officers no later than seven business days after the service date of the review officer 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 subsection (4)(a) of this section, 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~~)) request 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~~)) request 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 prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-2140 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 school employees benefits board (SEBB) organization or SEBB 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 the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2150 Review officer or officers—Designation and authority. (1) The designation of a review officer or officers ((~~shall~~)) must be consistent with the requirements of RCW 34.05.491 and the review officer or officers ((~~shall~~)) must not have personally participated in the decision made by the school employees benefits board (SEBB) organization or SEBB program.

(2) The review officer or officers ((~~shall~~)) must 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; or

(b) Reverse the initial order in whole or in part; or

(c) ((~~Refer~~)) Convert the matter ((~~for~~)) to 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 the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-2160 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 of RCW 34.05.413 through 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director designates a 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 182-32-010 through 182-32-130 and WAC 182-32-3000 through 182-32-3200 apply to the formal administrative hearing.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3000 Formal administrative hearings. (1) When a brief adjudicative proceeding is converted to a formal administrative hearing consistent with WAC 182-32-2160, 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 34-05-476.

(3) Part III describes the general rules and procedures that apply to school employees benefits board (SEBB) 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 school employees benefits board (SEBB) benefits formal administrative hearings. Other procedural rules adopted in chapters 182-30, 182-31, and 182-32 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 III, the procedural rules adopted in ((~~this~~)) Part III ((~~shall~~)) must govern.

(c) If there is a conflict between ((~~this~~)) Part III and specific SEBB program rules, the specific SEBB program rules prevail. SEBB program rules are found in chapters 182-30 and 182-31 WAC.

(d) Nothing in ((~~this~~)) Part III 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 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-3015 Hearing officers—Assignment, motions of prejudice, and disqualification. (1) **Assign-**

ment: A hearing officer will be assigned at least five business days before a hearing. A party may ask which hearing officer is assigned to a hearing by contacting the hearing officer's office listed on the notice of hearing. If requested by a party, the hearing officer's office must send the name of the assigned hearing officer to all parties, by electronic mail or in writing, at least five business days before the scheduled hearing date.

(2) **Motion of prejudice:** Any party requesting a different hearing officer may file a written motion of prejudice against the hearing officer assigned to the matter before the hearing officer rules on a discretionary issue in the case, admits evidence, or takes testimony.

(a) A motion of prejudice must include a declaration stating that a party does not believe the hearing officer can hear the case fairly. Service of copies of the motion must also be made to all parties listed on the notice of hearing.

(b) Any party's first motion of prejudice will be automatically granted. Any subsequent motion of prejudice made by a party may be granted or denied at the discretion of the hearing officer no later than seven days after receiving the motion.

(c) A party may make an oral motion of prejudice at the beginning of a hearing before the hearing officer rules on a discretionary issue in the matter, admits evidence, or takes testimony if:

(i) The hearing officer was not assigned at least five business days before the date of the hearing; or

(ii) The hearing officer was changed within five business days of the date of the hearing.

(3) **Disqualification:** A hearing officer may be disqualified from presiding over a hearing for bias, prejudice, conflict of interest, or ex parte contact with a party to the hearing.

(a) Any party may file a petition to disqualify a hearing officer as described in RCW 34.05.425. A petition to disqualify must be in writing and service promptly made to all parties and the hearing officer upon discovering facts of possible grounds for disqualification.

(b) The hearing officer whose disqualification is requested will determine whether to grant or deny the petition in a written order, stating facts and reasons for the determination. The hearing officer must serve the order no later than seven days after receiving the petition for disqualification.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3100 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 formal administrative hearing under circumstances identified in this 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.

(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 (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 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3120 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 health care authority (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 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 ((~~182-32-2120 and 182-32-2130~~)) 182-32-3180 and 182-32-3200.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3140 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 182-32-3080. 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 with good cause 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 the health care authority's final decision without further action.

(6) If the hearing officer ((~~will consider if there is~~)) 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 ((~~and~~)), conclusions of law ((~~supporting the decision of whether to reinstate~~)), and the 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 except WAC 182-16-3140(8).

AMENDATORY SECTION (Amending WSR 19-01-055, filed 12/14/18, effective 1/14/19)

WAC 182-32-3170 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 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, the hearing officer must:

(a) Identify the order as a final order of the school employees benefits board (SEBB) 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 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3180 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 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 reconsideration, 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~~)) prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-32-3190 Decisions on requests for reconsideration. (1) Unless the request for reconsideration is denied as untimely filed under WAC 182-32-3180, the same hearing officer who entered the final order, if reasonably available, will also ((~~dispose of~~)) decide 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 182-32-3180 (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.

WSR 20-16-077
PERMANENT RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket U-180525, General Order R-600—Filed July 29, 2020, 12:46 p.m., effective August 29, 2020]

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 20-17 issue of the Register.

WSR 20-16-108
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed July 31, 2020, 12:11 p.m., effective August 31, 2020]

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

Purpose: Chapter 246-710 WAC, Children and youth with special health care needs program, the department of health (department) adopted the following changes to ensure clear, consistent guidance for the program and clients to better understand the supports available: (1) Updated the rules to current standards; (2) amended to include accessing the department as a payer of last resort, and repayment to the department under certain circumstance; and (3) added new sections to include programs such as Neurodevelopmental Centers.

The children and youth with special health care needs program at the department is a required program under the maternal and child health block grant from the United States Health Resources and Services Administration. This rule will fulfill that requirement by ensuring clear, consistent guidance for the program and clients so they can better understand the supports available and have better access to services.

Citation of Rules Affected by this Order: New WAC 246-710-100 and 246-710-110; and amending WAC 246-710-001, 246-710-010, 246-710-030, 246-710-050, 246-710-060, 246-710-070, 246-710-080, and 246-710-090.

Statutory Authority for Adoption: RCW 43.70.040, 43.70.080, 43.70.120.

Adopted under notice filed as WSR 20-03-118 on January 16, 2020.

A final cost-benefit analysis is available by contacting Ashley Noble, P.O. Box 47890, Olympia, WA 98504-7890, phone 360-628-3776, TTY 711, email ashley.noble@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 2, Amended 8, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 2, Amended 8, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 2, Amended 8, Repealed 0.

Date Adopted: July 30, 2020.

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

Chapter 246-710 WAC

((~~COORDINATED CHILDREN'S SERVICES~~)) CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-001 Declaration of purpose. ((~~The following rules implement RCW 43.20.140 and chapter 43.70 RCW. The state board of health may develop rules that are necessary to implement RCW 43.20A.635 authorizing the secretary of the department of health to administer a program of services for children with special health care needs.~~)) The purpose of the ((~~CSHCN~~)) children and youth with special health care needs (CYSHCN) program is to ((~~develop, extend, and improve services and service systems for locating, diagnosing, and treating children with special health care needs within available resources~~)) assure comprehensive, coordinated, integrated, family-centered, and culturally competent systems of care. The CYSHCN program focuses on developing, extending, and improving services and service systems for identifying, diagnosing, and treating infants, children, and youth up to eighteen years of age who have or are at risk of developing chronic physical, developmental, behavioral, or emotional conditions, or any combination thereof, and require health and related services of a type beyond what is required by children generally. The program works to ensure CYSHCN are able to achieve the healthiest lives possible and develop to their fullest potential by building the capacity of communities to support CYSHCN and their families while developing and enhancing the capacity of statewide systems of care that are comprehensive, coordinated, integrated, family-centered, community-based, and culturally appropriate with the purpose of supporting and promoting health equity.

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Children and youth with special health care needs" or "CYSHCN" means children and youth up to eighteen years of age who have or are at increased risk of developing chronic physical, developmental, behavioral, or emotional conditions which require health and related services of a type or amount beyond that required by children generally.

(2) "Client" means ((~~an individual~~)) a child or youth with special health care needs((~~, seventeen years of age or younger, who is being served by~~)) who is receiving services from a local ((~~CSHCN~~)) CYSHCN agency.

(((~~(2) "Children with special health care needs" means children with disabilities or handicapping conditions; chronic illnesses or conditions; health related educational or behavioral problems; or children at risk of developing such disabilities, conditions, illnesses or problems.~~)))

(3) ((~~"CSHCN" means the children with special health care needs program~~)) "CYSHCN program" means the program administered in the state of Washington by the department funded through the federal Title V Maternal Child Health block grant and other discretionary funding when available.

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

(5) "DX/TX funds" means diagnostic and treatment funds managed by the department that are used to pay for medically necessary services which are not covered by the HCA-medicaid program or other funding sources responsible and available for the care of a child or youth participating in the CYSHCN program.

(6) "Health care authority," "HCA," or "authority" means the state agency responsible for the administration of Washington state's medicaid program.

(7) "Local ((~~CSHCN~~)) CYSHCN agency" means the local health jurisdiction or other ((~~agency locally administering the CSHCN~~)) local agency designated by the department to administer the CYSHCN program for the county where the client resides ((~~in the state of Washington.~~

~~(6) "Service systems" means community-based systems of services such as primary and specialty medical services, early intervention, special education, and social and family support services for children with special health care needs and their families.~~

~~(7)~~)).

(8) "Nonphysician provider" means any medical, behavioral, developmental or social support worker or organization that has been determined by the department to provide services for CYSHCN, that does not hold an allopathic or osteopathic physician's license.

(9) "Services" means health-related interventions((~~,~~)) including, but not limited to:

(a) Early identification((~~,~~));

(b) Referrals for additional screening and diagnostic services;

(c) Care coordination((~~,~~));

(d) Case management;

(e) Family support;

(f) Health education and life skills;

(g) Medical, ((~~surgical~~)) habilitative and ((~~rehabilitation care,~~)) rehabilitative services; and

(h) Equipment provided in ((~~hospitals, clinics, offices, and homes~~)) the client's home or community setting by local ((~~CSHCN~~)) CYSHCN agencies, physicians and ((~~other health care~~)) nonphysician providers.

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-030 ((~~Program limitations.~~)) Scope and eligibility. (((~~(1) The department may reduce the scope of CSHCN services and impose or revise funding limitations on certain services when required for budgetary reasons to accommodate available funding.~~

~~(2) Financial eligibility for a client must be determined annually when health-related services and equipment are paid for with CSHCN funds. Financial eligibility will be determined according to national standards of living for low-income families such as federal poverty levels or state median income adjusted for family size. Financial eligibility is not entitlement to CSHCN services.~~))

(1) A child, youth, or family with a current address in Washington state is eligible for services if the child or youth is younger than eighteen years of age, and has one or more of the following:

(a) A disability or disabling condition(s);

(b) Chronic illness or condition(s);

(c) Health-related educational or behavioral condition(s); or

(d) A risk of developing disabilities, chronic conditions, or health-related educational and behavioral conditions.

For the purposes of subsection (1) of this section, length of stay in the state is not considered in determining residency.

(2) Financial eligibility is not considered in determining client eligibility for the CYSHCN program except as outlined in subsection (3) of this section regarding DX/TX funds.

(3) Some services may be covered for established clients who are eighteen to twenty-one years of age, provided that the service or treatment:

(a) Was previously planned as a continued stage of treatment required to achieve health goals;

(b) Was initiated before the client turned eighteen;

(c) Has a definable treatment course with a clear end point; and

(d) Will not be authorized after a client's twenty-first birthday.

(4) A client may, at the discretion of the department, be eligible for DX/TX funds if they meet either of the following:

(a) Eligible for medicaid without monthly premiums; or

(b) Have current eligibility approved by the HCA-medicaid program, or the women, infants, and children program.

(5) A client shall request and the department shall determine DX/TX financial eligibility annually.

(6) DX/TX funds are not an entitlement. DX/TX funds are subject to medical necessity review by the local CYSHCN agency and availability of funding. The department may reduce the scope of CYSHCN services and impose or revise funding limitations on certain services when required for any reason including, but not limited to, budgetary reasons.

(7) For the purposes of this section, "medical necessity" means services which are reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a disability or health condition, for which there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client. For the purposes of this definition, a course of treatment may include treatment, observation, or no treatment at all.

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-050 Authorization of ((~~services~~)) diagnostic and treatment (DX/TX) funds. ((~~Authorization for~~)) The department may authorize diagnostic and treatment services paid for with ((~~CSHCN~~)) CYSHCN funds ((~~will be accomplished~~)) in accordance with the following:

(1) ((~~Financial eligibility for a client has been determined.~~

~~(2) A request for services to be paid for with CSHCN funds has been reviewed for consistency with program directions. Services must be recognized as an acceptable form of treatment by a significant portion of the professional community.~~

~~(3) No services will be authorized~~)) The department shall make decisions about using DX/TX funds on a case-by-case basis. DX/TX funds are not intended for those items that are part of usual daily living expenses that are the responsibility of parents/caregivers. DX/TX funds are not entitlement funds and the local CYSHCN agency or the department may choose not to use those funds.

(2) The department may only make a decision about whether to pay for services with DX/TX funds once all of the following have been completed:

(a) Determination of financial eligibility for a client;

(b) Department receipt, review, and approval of a HSA form submitted electronically to the department by the local CYSHCN agency;

(c) Services must be recognized as an acceptable form of treatment by a significant portion of the professional community; and

(d) Determination by the department that the services are medically necessary.

(3) The department will not authorize payment for services for out-of-state providers if an equivalent service is available within the state of Washington. ((~~However, use of resources in bordering states will be authorized when appropriate.~~)) If an equivalent service is not available in Washington state, services for out-of-state providers may be approved by the department on a case-by-case basis.

(4) For the purposes of this section, "Health Services Authorization form" or "HSA form" means an electronic form which must be completed by the local CYSHCN agency and submitted to the department for approval or denial in order to access DX/TX funds to pay for service, treatment, or equipment.

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-060 Qualifications of ((~~hospitals and~~)) providers. ((~~Providers of services paid for with CSHCN funds must meet the following minimum qualifications.~~

~~(1) Hospitals will be:~~

~~(a) Accredited by the joint commission on the accreditation of health care organizations; and~~

~~(b) Licensed in the state where the hospital is located.~~

~~(2)~~)) The department shall determine the eligibility of qualified medical and nonmedical providers to receive payment out of DX/TX funds. A service may not be authorized for out-of-state providers if an equivalent service is available within the state of Washington. The department may authorize the use of resources in bordering states when appropriate. Providers of services paid for with DX/TX funds shall meet the following minimum qualifications:

(1) Physicians ((~~will be~~)), advanced registered nurse practitioners (ARNPs), and physician's assistants (PAs) must:

(a) ((~~Licensed to practice medicine in Washington, or other state~~)) Hold an active license in the jurisdiction where they practice; ((~~and~~

~~(b) Board-certified or board-eligible by the appropriate specialty board.~~

~~(3) Providers other than physicians will be:~~

~~(a) Licensed or certified in Washington or in the state where they practice; or~~

~~(b) Accredited by the appropriate national professional organization when there is no state licensure or certification process.~~))

(b) Be licensed, certified, or registered with the appropriate state authority and in good standing in the jurisdiction where they practice;

(c) Have no record of disciplinary action taken on his or her license in the previous five years; and

(d) Not be listed in the federal exclusions database.

(2) All other health providers not listed in subsection (1) of this section must:

(a) Where state or territorial licensing or certification exists for the person's profession, be:

(i) Licensed, certified, or registered with the appropriate state authority and in good standing in the jurisdiction where they practice; and

(ii) Have no record of disciplinary action taken on his or her license or certification in the previous five years; or

(b) Where state or territorial licensing or certification does not exist for the person's profession, be:

(i) Accredited by the appropriate national professional organization; and

(ii) Have no record of discipline or misconduct related to that accreditation within the previous five years.

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-070 Provider diagnostic and treatment fund fees and payments. (1) Payments to providers ((~~of services~~)) using ((~~CSHCN~~)) DX/TX funds ((~~will~~)) must be made using the current ((~~CSHCN~~)) CYSHCN program standards and payment schedules, including the Washington state ((~~department of social and health services medical assistance administration~~)) HCA-medicaid fee schedule and the ((~~CSHCN~~)) CYSHCN program supplemental fee schedule.

(2) A provider ((~~will accept the fees paid under this section as full payment for~~)) shall consider payment to have been made in full for the services rendered when accepting the fees paid under this section.

(3) A provider may not bill or in any way seek billing or payment from a client for any remaining balances, unless the local CYSHCN agency has arranged for such billing before services were provided.

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-080 Third-party resources. ((~~CSHCN is a secondary payer to all private and other public funded health programs. The department may pay for services with CSHCN funds only after payment by all entitlement programs and by all other private and public funding resources~~)) The department shall be the payor of last resort to all private and other publicly funded health programs. The department may pay for services with DX/TX funds only after payment by all entitlement programs and all other private and public funding resources have been exhausted, except where prohibited by federal law.

AMENDATORY SECTION (Amending WSR 99-01-100, filed 12/17/98, effective 1/17/99)

WAC 246-710-090 Repayment. Repayment to the department from the provider, family or other source is required should insurance benefits, trusts, court-awarded damages or ((~~like~~)) similar funds become available, and where payments have been made to the ((~~family~~)) vendor or provider for services paid for by ((~~CSHCN~~)) DX/TX funds. A provider shall provide repayment to the department for overpayment made for services paid out of DX/TX funds. In instances where repayment is required, the vendor or provider must refund the DX/TX payment to the local CYSHCN agency payable to the department which the local CYSHCN agency must transfer to the department.

NEW SECTION

WAC 246-710-100 Neurodevelopmental centers (NDCs). (1) For the purposes of this section, "neurodevelopmental center (NDC) of excellence" means a department-designated nonprofit agency, hospital, or other organization located in Washington state that provides multidisciplinary pediatric assessment and treatment services including outreach, evaluation, diagnosis, treatment planning, and specialized therapies to CYSHCN up to twenty-one years of age.

(2) NDCs provide evaluation, diagnosis, and coordinated therapies and may also, at the discretion of a child's primary care provider, refer for additional medical specialty consultation.

(3) NDCs may be designated by the department as neurodevelopmental centers of excellence. In order to be considered for NDC designation by the department, a NDC shall:

(a) Be licensed or capable of becoming licensed to do business in the state of Washington;

(b) Maintain a formal relationship with a designated medical director with specialized pediatric training; and

(c) Employ occupational therapists licensed under chapter 18.59 RCW, physical therapists licensed under chapter 18.74 RCW, and speech language pathologists licensed under chapter 18.35 RCW with pediatric training on staff.

NEW SECTION

WAC 246-710-110 Data sharing. (1) The department's CYSHCN program has a federal mandate under Title V of the Social Security Act (42 U.S.C. 701 et seq.) to ensure that the HCA-medicaid program is made aware of medicaid-enrolled recipients of services through Title V. The purpose of this mandate is to ensure the medicaid agency is able to identify a child or youth who has special health care needs in order for the authority to offer care coordination and other services.

(2) The department shall take appropriate measures to safeguard any information gathered, and shall share information with only those agencies with a legitimate need to know or to comply with federal law. Consent to share client information with agencies outside of the local CYSHCN agency requires a separate release of information form signed by the parent or guardian.

(3) The department may create and release data files for public use, provided that these files do not contain any direct or indirect patient identifiers.

(4) The following definitions apply for the purpose of this section:

(a) "Direct identifier" means a single data element that identifies an individual person.

(b) "Indirect identifier" means a single data element that on its own might not identify an individual person, but when combined with other indirect identifiers is likely to identify an individual person.

WSR 20-16-126
PERMANENT RULES
GAMBLING COMMISSION

[Filed August 3, 2020, 8:38 a.m., effective September 3, 2020]

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

Purpose: RCW 42.56.120 authorizes agencies to charge for certain costs related to public records requests. This statute allows agencies to undergo their own cost-analysis determination or to choose the default rates established in the statute if calculating actual costs would be unduly burdensome. The gambling commission does not have the resources to conduct a study to determine actual costs and doing so would interfere with other essential functions of the agency, and therefore chooses to adopt the default rate established in statute to address the growing costs associated with public records requests.

Citation of Rules Affected by this Order: New WAC 230-21-016 Costs of providing public records.

Statutory Authority for Adoption: RCW 9.46.070.

Other Authority: RCW 42.56.120.

Adopted under notice filed as WSR 20-12-047 on May 28, 2020.

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 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: July 21, 2020.

Ashlie Laydon
Rules Coordinator

NEW SECTION

WAC 230-21-016 Costs of providing public records. (1) There is no fee for the inspection of public records.

(2) Pursuant to RCW 42.56.120(2), we are not calculating all actual costs for copying records because to do so would be unduly burdensome for the following reasons:

(a) We do not have the resources to conduct a study to determine actual copying costs for all of our records; and

(b) To conduct such a study would interfere with other essential agency functions; and

(c) Through the 2017 legislative process, the public and requestors have commented on and been informed of authorized fees and costs, including for electronic records, provided in RCW 42.56.120 (2)(b) and (c), (3), and (4).

(3) We may charge fees for the production of copies of public records consistent with the fee schedule established in RCW 42.56.120. The fee schedule also is published on our website at www.wsgc.wa.gov and a copy of the fee schedule will be made available at agency headquarters listed in WAC 230-01-005.

(4) Before copying requested public records, we may require a deposit of up to ten percent of the estimated costs of copying all of the records. We may also require payment of the remainder of the copying costs before providing all of the records, or the payment of the costs of copying an installment before providing the installment.

(5) We may provide customized electronic access to public records if we estimate that the request would require the use of information technology expertise to prepare data compilations, or provide customized electronic access services when such compilations and customized access services are not used by us for any other agency purposes. We will charge the actual costs, including staff time, necessary to reimburse our agency for providing customized electronic access services.

(6) We will not release any requested copies of public records unless and until the requestor has paid all copying and other charges set forth in this section.

(7) Payment may be made by cash, check, or money order to the Washington state gambling commission. Cash payments must be in the exact amount and delivered to the physical address listed in WAC 230-01-005.

(8) We may waive fees for providing public records at the discretion of the director or director's designee. This determination will be made on a case-by-case basis.

WSR 20-16-127
PERMANENT RULES
BOARD OF ACCOUNTANCY

[Filed August 3, 2020, 8:41 a.m., effective January 1, 2021]

Effective Date of Rule: January 1, 2021.

Purpose: Rule making is needed to: (1) Eliminate the initial licensing requirement to achieve and document a passing grade of ninety percent or better on a board-approved initial course covering the Washington State Public Accountancy Act, related board rules, and board policies; (2) rename the rule section.

Citation of Rules Affected by this Order: Amending WAC 4-30-080.

Statutory Authority for Adoption: RCW 18.04.055.

Adopted under notice filed as WSR 20-10-104 on May 6, 2020.

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 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: July 31, 2020.

Charles E. Satterlund, CPA
Executive Director

AMENDATORY SECTION (Amending WSR 20-02-059, filed 12/24/19, effective 1/24/20)

WAC 4-30-080 ((~~How do I apply for an~~)) Initial individual CPA license((~~?~~)) requirements. (1) To qualify to apply for an initial license you must meet the following criteria and requirements:

(a) Good character requirements of RCW 18.04.105 (1)(a);

(b) Education requirements of WAC 4-30-060;

(c) Examination requirements of WAC 4-30-062;

(d) Experience requirements of WAC 4-30-070;

(e) Achieve and document a passing grade of ninety percent or better on a course covering the complete content of the AICPA Code of Professional Conduct((~~;~~

~~(f) Achieve and document a passing grade of ninety percent or better on a board-approved initial course covering the Washington State Public Accountancy Act, related board rules, and board policies~~)).

(2) If more than four years have lapsed since you passed the examination, you must meet the CPE requirements of WAC 4-30-134(5) within the thirty-six month period immediately preceding submission of your license application. That CPE must include CPE hours in ethics and regulation meeting the requirements of WAC 4-30-132(7). This regulatory ethics portion of the combined one hundred twenty-hour CPE requirement must be completed within the six month period immediately preceding submission of your license application.

(3) You must provide the required information, documents, and fees to the board either by making application through the board's online application system or on a form provided upon request. You must provide all requested information, documents and fees to the board before the application will be evaluated.

(4) Upon assessment of your qualifications and approval of your application, your licensed status will be posted in the board's licensee database and, therefore, made publicly available for confirmation. A hard copy of your license can be provided upon request.

(5) Your initial license will expire on June 30 of the third calendar year following initial licensure.

(6) You may not use the title CPA until the date the approval of your license is posted in the board's licensee database and, therefore, made publicly available for confirmation.

WSR 20-16-128
PERMANENT RULES
BOARD OF ACCOUNTANCY

[Filed August 3, 2020, 8:44 a.m., effective September 3, 2020]

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

Purpose: Rule making is needed to:

WAC 4-30-100 and 4-30-102 to: (1) Rename the rule; (2) add requirements from board policy into the rule; and (3) specify the requirements for foreign reciprocity licensure.

Citation of Rules Affected by this Order: Amending WAC 4-30-100 and 4-30-102.

Statutory Authority for Adoption: RCW 18.04.055.

Adopted under notice filed as WSR 20-10-106 on May 6, 2020.

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 2, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 2, 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: July 31, 2020.

Charles E. Satterlund, CPA
Executive Director

AMENDATORY SECTION (Amending WSR 10-24-009, filed 11/18/10, effective 12/19/10)

WAC 4-30-100 ((~~What are the rules governing~~)) Reciprocity for accountants from foreign countries((~~?~~)). (1) Under the authority provided by RCW 18.04.183, the board ((~~may rely~~)) relies on the National Association of State Boards of Accountancy((~~,~~)) (NASBA) and the American Institute of Certified Public Accountants (AICPA), who have jointly established the United States International Qualifications Appraisal Board (IQAB) to eliminate impediments to reciprocity, or other professional bodies for evaluation of foreign accounting credential equivalency. IQAB serves as the link between the accounting profession in the United States and the accounting professions of other General Agreement on Trade Services (GATS) signatory countries. Through mutual recognition agreements (MRA), covered individuals will have similar provisions within each reciprocal country.

(2) ((~~Your~~)) The foreign accounting credential may be accepted in partial satisfaction of licensing requirements if:

(a) ((~~You met~~)) The foreign issuing body's education, examination, and ethical requirements ((~~used to qualify its domestic candidates~~)) are equivalent to the requirements for licensure in this state;

(b) ((~~Your~~)) The foreign accounting credential is valid and in good standing at the time ((~~you apply~~)) of application for a Washington state license; and

(c) The foreign issuing body granting ((~~your~~)) the foreign accounting credential permits Washington CPAs an equivalent opportunity to receive the foreign accounting credential by reciprocity.

(((~~(d) You demonstrate satisfactory experience within the eight years prior to submitting your application in public accounting or other experience meeting the requirements of RCW 18.04.105 (1)(d).~~

~~The board will, by policy, identify acceptable foreign accounting credentials and acknowledge reciprocal agreements with bodies granting foreign accounting credentials.~~

~~(3) The board may require a qualifying examination(s) to determine if you possess adequate knowledge of U.S. practice standards and the board's regulations. The board will, by policy, specify the form of qualifying examination(s) and passing grade(s).~~

~~(4) You must:~~

~~(a) Meet the CPE requirements of WAC 4-30-134 for subsequent renewal of an initial license issued pursuant to the board's authority; and~~

~~(b) Achieve and document a passing grade of ninety percent or better on a course covering the complete content of the AICPA Code of Professional Conduct.~~

~~(5) If you hold a Washington state CPA license or certificate issued through the foreign reciprocity provisions of the act, you must notify the board of any investigations undertaken, or sanctions imposed, by a foreign credentialing body against your foreign credential within thirty days of your receiving notice that an investigation has begun or a sanction was imposed.~~

~~(6) If you hold a Washington state license or certificate issued through the foreign reciprocity provisions of the act, you must notify the board within thirty days if your foreign license, permit, or certificate has lapsed or otherwise becomes invalid.~~)) (3) The board requires a qualifying examination to determine if the individual possesses adequate knowledge of United States practice standards and the board's regulations.

(a) The board adopts the International Qualifications Examination (IQEX) prepared and graded by the AICPA as the appropriate examination to test the knowledge of the subject matter unique to the United States, as determined by the AICPA in cooperation with NASBA, of those applicants holding an accounting credential issued by professional credentialing institutes that have established current MRAs with IQAB.

(b) The board will continue to recognize passing grades from the predecessor Canadian Chartered Accountant Uniform CPA Qualification Examination (CAQEX).

(c) The board accepts IQEX grades from examinations administered by other state boards of accountancy or by NASBA.

(d) The board sets the passing score for the IQEX and CAQEX at 75.

AMENDATORY SECTION (Amending WSR 10-24-009, filed 11/18/10, effective 12/19/10)

WAC 4-30-102 ((~~How do I apply for an~~)) Initial Washington state license requirements for application through foreign reciprocity((~~?~~)). (1) To apply for an initial Washington state CPA license through foreign reciprocity, you must:

(a) Hold a license in a foreign country that meets the requirements of WAC 4-30-100 and request verification of licensure from the issuing professional accounting organization. The verification must be sent directly to the board from the issuing organization.

(b) Pass an examination meeting the requirements of WAC 4-30-100. You must request from NASBA that verification of exam score be sent directly to the board.

(c) Demonstrate, through completion and submission of the board's experience affidavit, satisfactory experience in public accounting or other experience meeting the requirements of RCW 18.04.105 (1)(d) within the eight years prior to submitting an application for licensure.

(d) Meet the CPE requirements in WAC 4-30-134.

(e) Achieve a passing grade of ninety percent or better on a course covering the complete content of the AICPA Code

of Professional Conduct and submit the course completion certificate.

(2) You must provide all required information, documents, and fees to the board either by making application through the board's online application system or on a form provided by the board upon request. You must provide all requested information, documents, and fees to the board before the application will be evaluated.

(3) Upon assessment of your qualifications and approval of your application, your license status will be posted in the board's licensee database and, therefore, made publicly available for confirmation. A hard copy of your license can be provided upon request.

(4) You may not use the title CPA until your status has been posted to the board's licensee database and, therefore, made available to the public.

(5) Your Washington state CPA license will expire on June 30 of the third calendar year following the calendar year of initial licensure.

((~~You may not use the title CPA until your status has been posted to the board's licensee database and, therefore, made available to the public.~~)) (6) You must meet the CPE requirements of WAC 4-30-134 for subsequent renewal of an initial license.

(7) You must notify the board within thirty days if your foreign license, permit, or certificate has lapsed or otherwise becomes invalid.

WSR 20-16-133
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed August 3, 2020, 1:49 p.m., effective September 3, 2020]

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

Purpose: The department is amending WAC 388-493-0010 Working family support, to extend the working family support program through June 30, 2021.

Citation of Rules Affected by this Order: Amending WAC 388-493-0010.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090; and chapter 415, Laws of 2019.

Adopted under notice filed as WSR 20-09-095 on April 15, 2020.

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 0, Amended 1, Repealed 0.

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

Date Adopted: August 3, 2020.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 17-23-050, filed 11/9/17, effective 12/10/17)

WAC 388-493-0010 Working family support. (1) What is the working family support (WFS) program?

The working family support program is administered by the department of social and health services (department) and provides an additional monthly food benefit from May 2016 through June 30, ((~~2019~~)) 2021 to low income families who meet specific criteria. Continuance of the program beyond June 30, ((~~2019~~)) 2021 is contingent on specific legislative funding for the working family support program.

(2) The following definitions apply to this program:

(a) "Co-parent" means another adult in your home who is related to your qualifying child through birth or adoption.

(b) "Qualifying child" means a child under the age of eighteen who is:

(i) Your child through birth or adoption; or

(ii) Your step-child.

(c) "Work" means subsidized or unsubsidized employment or self-employment. To determine self-employment hours, we divide your net self-employment income by the federal minimum wage.

(3) Who is eligible for the working family support program?

You may be eligible for working family support food assistance if you meet all of the following:

(a) You receive food assistance through basic food, food assistance program for legal immigrants (FAP), or transitional food assistance (TFA);

(b) Receipt of working family support food assistance would not cause your countable food assistance income to exceed the two hundred percent federal poverty level (FPL);

(c) No one in your food assistance unit receives temporary assistance for needy families (TANF) or state family assistance (SFA);

(d) A qualifying child lives in your home;

(e) You, your spouse, or co-parent work a minimum of thirty-five hours a week, and if you live with your spouse or co-parent, you must be in the same assistance unit;

(f) You provide proof of the number of hours worked; and

(g) You reside in Washington state as required under WAC 388-468-0005.

(4) How may I apply for working family support?

(a) The department will review your eligibility for the working family support program:

(i) When you apply for food assistance, or

(ii) At the time of your food assistance eligibility review.

(b) You may request the working family support benefit in person, in writing, or by phone at any time.

(5) How long may I receive working family support?

(a) You may recertify up to an additional six months for working family support if you meet the criteria listed in subsection (3) of this section and provide current proof that you, your spouse, or co-parent works a minimum of thirty-five hours a week.

(b) Working family support certification ends when:

(i) You complete either a certification or mid-certification review for food assistance under WAC 388-434-0010 or 388-418-0011, and you do not provide proof of the number of hours that you, your spouse, or your co-parent work;

(ii) You no longer receive basic food, FAP, or TFA;

(iii) You receive TANF or SFA;

(iv) You do not have a qualifying child in your home;

(v) You, your spouse, or co-parent no longer work a minimum of thirty-five hours a week; or

(vi) You are no longer a resident of Washington state.

(6) What benefits will I receive if I am eligible for the working family support program?

(a) The assistance unit will receive a separate ten dollars monthly food assistance benefit each month.

(b) Working family support benefits are not prorated.

(7) Enrollment in the working family support program is limited to ten thousand households per month.

WSR 20-16-141
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed August 4, 2020, 12:09 p.m., effective August 4, 2020]

Effective Date of Rule: August 4, 2020.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: This rule permanently adopts requirements of the expedited rule filed on June 2, 2020, as WSR 20-12-092. The earlier adoption date is needed as the content is explicitly and specifically dictated by statute.

Purpose: This rule making enacts the 2020 plumber law (chapter 153, Laws of 2020, SB 6170) and adopts the following:

- Creates a residential service plumbing certificate.
- Amends the acceptable supervisory ratios of plumber trainees to certified plumbers and authorizes remote supervision in certain circumstances.
- Increases the number of members on the advisory board of plumbers.
- Adjusts fees related to journey level and specialty plumber certification.

An expedited rule (WSR 20-12-092) was filed on June 2, 2020.

Citation of Rules Affected by this Order: Amending WAC 296-400A-005, 296-400A-010, 296-400A-020, 296-400A-022, 296-400A-023, 296-400A-028, 296-400A-029, 296-400A-035, 296-400A-045, 296-400A-120, 296-400A-121, 296-400A-300, and 296-400A-400.

Statutory Authority for Adoption: Chapter 153, Laws of 2020, SB 6170.

Adopted under notice filed as WSR 20-12-092 on June 2, 2020.

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 13, 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 0, Repealed 0.

Date Adopted: August 4, 2020.

Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-005 What definitions do I need to know to understand these rules? Unless a different meaning is clearly required by the context, the following terms and definitions are important:

"Advisory board" is the state advisory board of plumbers.

"Assist" means a friend, neighbor, or other person (including a certified plumber) may assist a householder, at his or her residence, in the performance of plumbing work on the condition that the householder is present when the work is performed and the person assisting the householder does not accept money or other forms of compensation for the volunteer work. For the purposes of this subsection, a residence is a single-family residence.

"Audit" means an assessment, evaluation, examination or investigation of, contractor's accounts, books and records for the purpose of verifying the contractor's compliance with RCW 18.106.320.

"Backflow assembly" or **"backflow prevention assembly"** or **"backflow preventer"** is a device as described in the *Uniform Plumbing Code* used to prevent the undesired reversal of flow of water or other substances through a cross-connection into the public water system or consumer's potable water system.

"Backflow assembly tester" is an individual certified by the department of health to perform tests to backflow assemblies.

"Calendar day" means each day of the week, including weekends and holidays.

"Continuing education" is approved plumbing and electrical courses for journey level, domestic pump specialty plumbers, and residential specialty plumbers, to meet the requirements to maintain their plumbing certification and for trainees or individuals to become certified plumbers in Washington.

"Continuing education course provider" is an entity approved by the department, in consultation with the state advisory board of plumbers, to provide continuing education training for journey level, domestic pump specialty plumbers, residential specialty plumbers, and trainees. All training course providers must comply with the requirements in WAC 296-400A-028.

"Continuity affidavit" is a form developed by the department that is used to verify whether medical gas pipe installation work (brazing process) has been performed biannually. This form is provided to the department at the time of renewal by the person holding the medical gas piping installer endorsement and requires the notarized signature of the employer of the medical gas piping installer or another qualified verifier as determined by the department. Continuity is a visual examination by the employer of the brazing that was performed. The medical gas installer must also review the current medical gas code and sign the affidavit stating that they have done so.

"Contractor" means any person, corporate or otherwise, who engages in, or offers or advertises to engage in, any work covered by the provisions of chapter 18.106 RCW by way of trade or business, or any person, corporate or otherwise, who employs anyone, or offers or advertises to employ anyone, to engage in any work covered by the provisions of chapter 18.106 RCW and is registered as a contractor under chapter 18.27 RCW.

"Control" means that the journey level plumber, specialty plumber, or temporary permit plumber is physically on-site at the start of each day and each and every job site to diagnose, direct, and lay out the plumbing work the trainee is to perform.

"Course of study" means classroom training and practical work experience in the plumbing industry as defined in WAC 296-400A-100.

"Department" is the department of labor and industries.

"Director" is the director of the department of labor and industries or designee.

"Dispatcher" means the contractor's employee who authorized the work assignment of the person employed in violation of chapter 18.106 RCW.

"Journey level plumber" is anyone who has learned the commercial plumbing trade and has been issued a journey level certificate of competency by the department. A journey level plumber may work on plumbing projects including residential, commercial and industrial worksite locations.

"Medical gas piping installer" is anyone who has been issued a medical gas piping installer endorsement of competency by the department.

"Medical gas piping systems" are piping systems that convey or involve oxygen, nitrous oxide, high pressure nitrogen, medical compressed air, ((~~or~~)) and other medical gas or equipment including, but not limited to, medical vacuum systems.

"Multiunit" is a multi-single family residence contained in a building or group of buildings that do not exceed three stories on any portion of the building.

"Plumbing" is that craft involved in installing, altering, repairing and renovating potable water systems, liquid waste systems and medical gas piping systems in the footprint of a building. Potable water systems, liquid waste systems, and medical gas piping systems are defined by the current *Uniform Plumbing Code* (UPC) and amendments adopted by the state building code council. All piping, fixtures, pumps and plumbing appurtenances that are used for rain water catchment and a reclaimed water system are included in the definition of liquid waste systems. ((~~The installation of water softening or water treatment equipment into a water system is not considered plumbing.~~))

"Records" include, but are not limited to, all bids, invoices, billing receipts, time cards and payroll records that show the work was performed, advertised, or bid.

"Residential service" is limited to performing residential service in single-family dwellings and duplexes and can only repair or replace previously existing fixtures, piping, and fittings that are outside the interior wall or above the floor.

"Specialty plumber" is anyone who has been issued a specialty plumbers certificate of competency by the department limited to:

(a) Installation, maintenance and repair of plumbing for single-family dwellings, duplexes and apartment buildings which do not exceed three stories;

(b) Maintenance and repair of backflow assemblies located within a residential or commercial building or structure. For the purposes of this subsection, "maintenance and repair" includes cleaning and replacing internal parts of an assembly, but does not include installing or replacing backflow assemblies.

(c) "Domestic pump specialty" means the installation, maintenance, and repair of a domestic water pumping system consisting of the pressurization, treatment, and filtration components of a domestic water system consisting of: One or more pumps; pressure, storage, and other tanks; filtration and treatment equipment; if appropriate, a pitless adapter; along with valves, transducers, and other plumbing components that:

(i) Are used to acquire, treat, store, or move water suitable for either drinking or other domestic purposes, including irrigation, to:

(A) A single-family dwelling, duplex, or other similar place of residence;

(B) A public water system, as defined in RCW 70.119.-020 and as limited under RCW 70.119.040; or

(C) A farm owned and operated by a person whose primary residence is located within thirty miles of any part of the farm;

(ii) Are located within the interior space including, but not limited to, an attic, basement, crawl space, or garage, of a residential structure, which space is separated from the living area of the residence by a lockable entrance and fixed walls, ceiling, or floor;

(iii) If located within the interior space of a residential structure, are connected to a plumbing distribution system supplied and installed into the interior space by either:

(A) A person who, pursuant to RCW 18.106.070 or 18.106.090, possesses a valid temporary permit or certificate of competency as a journey level plumber, specialty plumber, or trainee, as defined in this chapter; or

(B) A person exempt from the requirement to obtain a certified plumber to do such plumbing work under RCW 18.106.150.

For the purposes of the domestic pump specialty, residential structure includes any improvement to real property where that property is primarily used as a residence.

"Story" is defined by the current building codes and amendments adopted by the state building code council which includes basements or garages.

"Supervision" for the purpose of these rules means within sight and sound. Supervision requirements are met when the supervising plumber is on the premises and within sight and sound of the individual who is being trained. "Exception" for remote service trainee supervision available via mobile phone or a similar device on residential structure and meeting all other requirements under RCW 18.106.070 and the requirements for service plumbing under RCW 18.106.010.

"Trainee plumber" is anyone who has been issued a trainee certificate and is learning or being trained in the plumbing trade with direct supervision of either a journey level plumber or specialty plumber working in their specialty.

"Training course provider" is an entity approved by the department, in consultation with the state advisory board of plumbers, to provide medical gas piping installer training. All training course providers must comply with the requirements in WAC 296-400A-026.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-010 Plumbing certificate types and scope of work. (1) **Journey level plumber (PL01):** A journey level plumber may work on all phases of plumbing projects including residential, commercial and industrial worksite locations.

(2) **Residential specialty plumber (PL02):** Installation, maintenance and repair of all phases of plumbing for single-family dwellings, duplexes and apartment buildings which do not exceed three stories.

(3) **"Residential service"** is limited to performing residential service in single-family dwellings and duplexes and can only repair or replace previously existing fixtures, piping, and fittings that are outside the interior wall or above the floor. Does not include like-in-kind replacement of household appliances or other small utilization equipment that requires limited electric power and limited waste and/or water connections.

(4) **Backflow specialty plumber (PL30):** Maintenance and repair of backflow assemblies located within a residential or commercial building or structure. For the purposes of this subsection, "maintenance and repair" includes cleaning and replacing internal parts of an assembly, but does not include installing or replacing backflow assemblies. A plumber trainee must have a PT31 certificate in order to work as a backflow specialty plumber under the supervision of a certified backflow specialty plumber, certified residential specialty plumber or certified journey level plumber. PT31 trainee requires one hundred percent supervision.

((~~(4)~~)) (5) **Pump and irrigation specialty plumber (PL03):** Installation, maintenance and repair of equipment that is used to acquire, treat, store, or move water suitable for either drinking or other domestic purposes, including irrigation or to a domestic water pumping system consisting of the pressurization, treatment, and filtration components of a domestic water system consisting of: One or more pumps; pressure, storage, and other tanks; filtration and treatment equipment. For the purposes of this subsection, if located within the interior space of a residential structure as stated in RCW 18.106.010 ((~~(10)~~)) (14)(c), only the equipment and piping defined by RCW 18.106.010 ((~~(10)~~)) (14)(c) are included in this specialty and other parts of the system must be worked on by the appropriate certification.

((~~(5)~~)) (6) **Limited volume domestic pump specialty plumber (PL03A):** Installation, maintenance and repair of equipment that is used to acquire, treat, store, or move water suitable for either drinking or other domestic purposes on pumping systems not exceeding one hundred gallons per minute. A domestic water pumping system consisting of the pressurization, treatment, and filtration components of a domestic water system consisting of: One or more pumps; pressure, storage, and other tanks; filtration and treatment equipment. For the purposes of this subsection, if located within the interior space of a residential structure as stated in RCW 18.106.010 ((~~(10)~~)) (14)(c), only the equipment and piping to stated equipment in this locked room can be worked on by this certification; other parts of the system must be worked on by the appropriate certification.

((~~(6)~~)) (7) **Plumber trainee (PT00 and PT31):** Is an individual learning the trade or craft of plumbing. Trainees are required to have and maintain a valid plumber's training certificate. Trainees will be accredited for those hours worked within the scope of their supervising plumber. Any plumber trainee may perform plumbing work within the scope of their supervising journey level or specialty plumber. A trainee must keep a record of the hours worked as a trainee as required by WAC 296-400A-120(3).

((~~(7)~~)) (8) **Certified journey level electricians, certified residential specialty electricians, or electrical trainees (EL01 and EL02):** According to RCW 18.106.150 (2)(b), a current plumbing certificate of competency or plumber trainee card is not required for: Certified journey level electricians, certified residential specialty electricians, or electrical trainees working for a general or residential specialty electrical contractor (EC01 or EC02) and performing exempt work under RCW 18.27.090(18). A plumber trainee must have an electrical trainee (ET00) certificate in order to work with a journey level electrician or residential specialty electrician.

The plumbing work must be directly and immediately appropriate to the like-in-kind replacement of a household fixture or its component(s) that requires limited power and waste/water connections.

An example would be replacing the heating element (a component) of an electric hot water heater. An electrician performing a like-in-kind replacement of an electric hot water tank could only disconnect and then reconnect the water supply lines to the tank and drain line from the tem-

perature and pressure relief valve. Gas hot water tanks are not part of the electrician's exemption.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-020 How do I obtain a certificate of competency? You can obtain a certificate of competency by completing the following requirements for:

(1) Journey level, residential, residential service, and domestic pump specialty plumber certificate:

(a) Submitting a competency examination application to the department;

(b) Paying the examination fee shown in WAC 296-400A-045(1);

(c) Submitting the required evidence of competency and experience to the department as required under WAC 296-400A-120 and 296-400A-121;

(d) Providing documentation to the department with continuing education requirements;

(e) Passing the competency examination;

(f) In lieu of (a), (b), and (c) of this subsection and with the approval of the advisory board, the department may accept the successful passage of an examination administered by a nationally recognized testing entity;

(g) For domestic pump specialty plumbers, in lieu of (a), (b), and (c) of this subsection and with the approval of the advisory board, the department may accept a certification issued by professional trade association; and

(h) Paying the certification issuance fee within ninety days of notification of passing the written examination. Failure to pay within ninety days will require reexamination.

(2) Backflow assembly maintenance and repair specialty certificate:

(a) Submitting a competency examination application to the department;

(b) Submitting evidence of a current backflow assembly tester certification issued by the department of health;

(c) Paying the application and certificate fee shown in WAC 296-400A-045(1);

(d) Passing the competency examination; and

(e) Paying the certification issuance fee within ninety days of notification of passing the written examination. Failure to pay within ninety days will require reexamination.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-022 What procedure is required for renewal of a journey level medical gas endorsement? (1) Maintain an active Washington state journey level certification.

(2) Submit affidavit of continuity verifying that brazing has been performed every six months during the renewal cycle.

(3) Submit affidavit of review of current medical gas code adopted by the Washington state building code council.

(4) Pay the appropriate fee: If renewal occurs before expiration of current endorsement, the renewal fee shown in WAC 296-400A-045; if renewal occurs within ninety days of expiration of current endorsement, you must pay a double renewal fee; if the current endorsement has been expired for ninety-one days or more, you must take an examination relating to medical gas installation administered by the department and pay the examination application fee shown in WAC 296-400A-045. Medical gas endorsement is renewed every ((~~two~~)) three years.

(5) Contractors must accurately verify and attest to brazing performed by the journey level by sending an affidavit of continuity to the department or in lieu of the biannual braze requirement from the contractor, a performed brazed coupon test documenting that the coupon was certified as passing from a department approved medical gas training course provider would be accepted.

(6) If affidavit of continuity and/or affidavit of review are not received within ninety days of expiration, the applicant will be required to retake the examination and pay the appropriate fees prior to being placed in active status.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-023 What process is required for renewal of plumber certificates of competency? (1) An individual must apply for renewal of their plumbing certificate before the expiration date of the certificate. The individual may not apply for renewal more than ninety days prior to the expiration date. ((~~Journey level residential specialty and backflow specialty plumber certificates are renewed every two years. Domestic pump specialty~~)) Plumber certificates are renewed every three years.

(2) An individual may renew their certificate within ninety days after the expiration date without reexamination if the individual pays the doubled renewal fee referenced in RCW 18.106.070.

(3) All applications for renewal received more than ninety days after the expiration date of the plumbing certificate require that the plumber pass the appropriate competency examination before being recertified.

(4) All applicants for plumbing certificate renewal must:

(a) Submit a complete renewal application;

(b) Pay all appropriate fees; and

(c) Provide accurate evidence that the individual has completed the continuing education requirements described in WAC 296-400A-028 (excluding backflow specialty).

If an individual files inaccurate or false evidence of continuing education information when renewing a plumbing certificate, the individual's plumbing certificate may be suspended or revoked.

(5) A journey level, domestic pump specialty, ((~~or~~)) residential specialty, or residential service plumber certificate holder who has not completed the required hours of continuing education on or before the renewal date must pay a doubled fee according to RCW 18.106.070. Also, if the required hours of continuing education are not completed within ninety days after the expiration date the applicant will be required to retake the examination and pay the appropriate fees prior to being placed in active status.

(6) Backflow specialty plumber certificate holders must submit evidence of an active backflow assembly tester certification issued by the department of health within ninety days

of their expiration date. If the backflow assembly tester evidence is not submitted within ninety days after the expiration date, the applicant will be required to retake the examination and pay the appropriate fees prior to being placed in active status.

(7) An individual may renew a suspended plumbing certificate by submitting a complete renewal application including obtaining and submitting the continuing education required for renewal. However, the certificate will remain in a suspended status for the duration of the suspension period.

(8) An individual may not renew a revoked plumbing certificate.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-028 What are the requirements for continuing education and classroom training?

What are the general and continuing education course requirements for journey level, residential specialty plumbers, domestic pump specialty plumbers, and plumber trainees?

(1) Journey level, residential specialty plumber, residential service, domestic pump specialty plumber, and plumber trainee.

(a) To be eligible for renewal of a journey level ((~~plumber or~~)), residential specialty, or residential service plumber certificate, the individual must have completed at least ((~~sixteen~~)) twenty-four hours of approved continuing education for each ((~~two~~)) three years of the prior certification period. Individuals will be required in the prior ((~~two~~)) three-year period to have completed a minimum of ((~~eight~~)) twelve hours of plumbing code and a minimum of four hours of electrical trade related classes from the currently adopted Washington state plumbing and electrical codes. The remaining ((~~four~~)) eight hours may be plumbing or electrical trade related classes.

(b) Domestic pump specialty plumbers must renew their domestic pump specialty certificate once every three years, on or before the individual's birthday. Individuals will be required to complete twenty-four hours of approved continuing education. The continuing education may comprise both electrical and plumbing education with a minimum of twelve of the required twenty-four hours of continuing education in plumbing for each three-year renewal cycle.

(c) Plumber trainees must complete at least eight hours per year of training from an approved continuing education course for each year of the prior certification period. Trainees will be required during a two-year period to complete at least eight hours of plumbing code and at least four hours of electrical trade related classes from the currently adopted Washington state plumbing and electrical codes. The remaining four hours may be plumbing or electrical trade related classes.

(d) Any portion of a year of a prior plumber certification period is equal to one year for the purposes of the required continuing education.

(2) An individual will not be given credit for the same approved continuing education course taken more than once in their renewal cycle. No credit will be granted for any course not approved by the department.

(3) Continuing education requirements do not apply to backflow specialty plumbers under chapter 18.106 RCW and this chapter.

Approval process - Continuing education course.

(4) The advisory board of plumbers or plumbing board subcommittee will review each continuing education course. The advisory board of plumbers or plumbing board subcommittee will recommend approval or disapproval to the department. The department will either approve or disapprove the course.

(5) To be considered for approval, a continuing education course must consist of not less than two hours of instruction and must be open to monitoring by a representative of the department and/or the plumbing board at no charge. If the department determines that the continuing education course does not meet or exceed the minimum requirements for approval, the department may revoke the course approval or reduce the number of credited hours.

(6) Approved courses must be based on:

(a) Currently adopted edition of the *Uniform Plumbing Code* with amendments as adopted by the state building code council and currently adopted *National Electrical Code*;

(b) Chapters 18.106 or 19.28 RCW or chapters 296-400A or 296-46B WAC; or

(c) Materials and methods as they pertain to the industrial practices of plumbing or electrical construction, building management systems, plumbing or electrical maintenance, or workplace health and safety.

(7) Code-update courses must be based on the currently adopted *Uniform Plumbing Code* with amendments as adopted by the state building code council or currently adopted *National Electrical Code*.

(a) Correspondence and online courses in the plumbing code or industry related plumbing category require thirty-five questions per hour of credit. Exams and answers required with course application.

(b) Correspondence and online courses in the industry related electrical category require twenty-five questions per hour of credit. Exams and answers required with course application.

(c) Classroom training requires one hour of instruction for each hour of credit.

(d) Course outline must support the number of hours requested.

Application - For continuing education course approval.

(8) All applications for course approval must be on forms provided by the department. The plumbing board and the department will only consider the written information submitted with the application when considering approval of the continuing education training course.

(9) The department will provide continuing education application forms to sponsors upon request. The course sponsor must submit an original completed application for course approval and three copies (unless submitted electronically using department prescribed technology) to the department. The department must receive the complete course application

from the sponsor in writing at least forty-five days before the first class requested for approval is offered.

(10) A complete application for course approval must include:

(a) The appropriate course application fee;

(b) Course title, number of classroom instruction hours, and whether the training is open to the public;

(c) Sponsor's name, address, contact's name and phone number;

(d) Course outline (general description of the training, including specific *Uniform Plumbing Code* or currently adopted *National Electrical Code* articles referenced);

(e) Lists of resources (texts, references, visual aids);

(f) Names and qualifications of instructors. Course instructors must show prior instructor qualification and experience similar to that required by the work force training and education coordinating board under chapter 28C.10 RCW;

(g) Any additional documentation to be considered; and

(h) A sample copy of the completion certificate issued to the course participants.

(11) The course sponsor seeking approval of a continuing education course will be notified of the subcommittee's decision within five days of the completed review of the application.

(12) If the application is not approved, the rejection notice will include an explanation of the reason(s) for rejection. If the course sponsor disagrees with the subcommittee's decision, the course sponsor may request a reconsideration hearing by the full plumbing board. A request to appeal course rejection must be received by the department forty-five days before a regularly scheduled board meeting. The course sponsor must submit, to the department, any additional information to be considered during the hearing, in writing, at least thirty days before the board hearing. The course sponsor must provide at least twenty copies of any written information to be submitted to the board.

Offering - Continuing education course.

(13) The course sponsor may offer an approved course for up to three years without additional approval. However, if the course is classified as code-update or code-related and a new edition of the *Uniform Plumbing Code* or *National Electrical Code* is adopted within the course approval period, the course approval will be considered automatically revoked and the course sponsor must submit a new application for review by the department and approval by the plumbing board subcommittee. On new code cycle years new code courses can be approved and taught three months prior to the formal adoption date.

(14) A continuing education course attended or completed by an individual before final approval by the plumbing board subcommittee cannot be used to meet the plumbing certificate renewal requirements.

Documentation - Washington approved training course attendance/completion.

(15) The department is not responsible for providing verification of an individual's continuing education history with the course sponsor.

(16) The course sponsor must provide the department with an accurate and typed course attendance/completion roster for each course given.

(a) The attendance/completion roster must be provided within thirty days of course completion.

(b) In addition, the course sponsor may provide the attendance/completion roster in an electronic format provided by the department.

(c) The attendance/completion roster must show each participant's name, Washington certificate number, course number, location of course, date of completion, and instructor's name. The typed roster must contain the signature of the course sponsor's authorized representative.

(17) If the course sponsor fails to submit the required attendance/completion rosters within thirty days of the course completion, the department may revoke or suspend the course approval.

(18) Course sponsors must award a certificate to each participant completing the course from which the participant will be able to obtain:

(a) Name of course sponsor;

(b) Name of course;

(c) Date of course;

(d) Course approval number;

(e) The number of continuing education units; and

(f) The type of continuing education units.

(19) The department will only use a copy of the sponsor's attendance/completion roster as final evidence that the participant completed the training course.

(20) The department will keep an electronic copy of submitted rosters of the continuing education courses on file only for audit purposes. The department is not responsible for the original of any completion certificate issued.

Documentation - Out-of-state training course attendance/completion.

(21) To apply continuing education units earned out-of-state from course sponsors who do not have state of Washington approved courses, one of the following conditions must be met:

(a) The individual must request that the course sponsor submit a complete continuing education course application and requirements as described in this section for in-state courses.

Application for course approval will not be considered more than three years after the date of the course.

(b) The department must have entered into a reciprocal agreement with the state providing course approval.

The participant must provide a copy of an accurate and completed award or certificate from the course sponsor identifying the course location, date of completion, participant's name, and Washington certificate number.

The department will only accept a copy of the sponsor's certificate or form as evidence that the participant attended and completed the course.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-029 What is the implementation schedule for the continuing education course requirements?

• Individuals that renew between July 1, ((~~2005~~)) 2020, and June 30, ((~~2006~~)) 2021, are required to complete ((~~eight~~)) sixteen hours of continuing education courses.

• Effective July 1, ((~~2006~~)) 2021, all journey level and residential specialty renewals will require ((~~sixteen~~)) twenty-four hours of continuing education.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-035 How can I be placed on inactive status? (1) To be placed on inactive status, you must meet these three requirements:

(a) You must currently be a certified plumber;

(b) Have your inactive status request submitted and approved by the department prior to the expiration date of your plumbing certificate; and

(c) Not be working in the plumbing trade.

Inactive status means that you are not currently working in the plumbing trade and you are not required to pay the certificate renewal fee or required continuing education.

(2) To be reinstated from inactive status, you must meet these requirements:

(a) If you have been in inactive status for less than five years, you may return to active status, without reexamination, by paying the reinstatement fee shown in WAC 296-400A-045 and meet continuing education requirements for your certification.

(i) Journey level and residential specialty plumbers are required to meet a minimum of ((~~sixteen~~)) twenty-four hours continuing education with a minimum of ((~~eight~~)) twelve hours of plumbing code and a minimum of ((~~four~~)) eight hours being in electrical training before being reinstated. The remaining four hours can be from any of the approved categories.

(ii) Domestic pump plumbers are required to complete twenty-four hours, with a minimum of twelve hours of plumbing classes before being reinstated.

(b) If you have been in inactive status for five or more years, you are required to reapply and pass the competency examination pursuant to WAC 296-400A-020 and pay the appropriate fees shown in WAC 296-400A-045.

(3) Inactive status does not apply to medical gas endorsements.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-045 What fees will I have to pay? The following are the department's plumbers nonrefundable fees: Fees related to journey level and specialty plumber certification:

Type of Fee	Period Covered by Fee	Dollar Amount of Fee
Examination application	Per examination	$((~~151.90~~)) 160.85
Domestic pump specialty application fee*******	Per application	$((~~151.90~~)) 160.85
Reciprocity application*	Per application	$((~~151.90~~)) 160.85
Trainee certificate**	One year or when hours are updated	$((~~45.20~~)) 47.85
Temporary permit (not applicable for backflow assembly maintenance and repair specialty)	((~~Four months~~)) One hundred twenty days	$((~~75.40~~)) 79.85
Journey level ((~~or~~)), residential specialty, or residential service certificate renewal or 1st card***	((~~Two~~)) Three years	$((~~121.60~~)) 193.15
Domestic pump specialty plumber certificate renewal or 1st card***	Three years	$((~~182.50~~)) 193.25
Backflow assembly maintenance and repair specialty certificate renewal or 1st card***	((~~Two~~)) Three years	$((~~83.90~~)) 133.25
Medical gas endorsement application	Per application	$((~~55.90~~)) 59.20
Medical gas endorsement renewal or 1st card***	((~~Two~~)) Three years	$((~~83.60~~)) 132.80
Medical gas endorsement examination fee****		See note below.
Medical gas endorsement training course fee*****		See note below.

Type of Fee	Period Covered by Fee	Dollar Amount of Fee
Domestic pump specialty examination fee****		See note below.
Reinstatement fee for residential and journey level certificates		$((~~243.90~~)) 258.30
Reinstatement fee for backflow assembly maintenance and repair specialty certificates		$((~~140.30~~)) 148.55
Reinstatement fee for domestic pump		$((~~365.20~~)) 386.75
Replacement fee for all certificates		$((~~20.50~~)) 21.70
Refund processing fee		$((~~32.60~~)) 34.50
Unsupervised trainee endorsement		$((~~32.60~~)) 34.50
Inactive status fee		$((~~32.60~~)) 34.50
Certified letter fee/verification of licensure		$((~~32.60~~)) 34.50
Documents copied from a plumber's file		$((~~2.00~~)) 2.10 per page maximum copy charge $((~~30.00~~)) 31.75
Continuing education new course fee******		$((~~197.50~~)) 209.15
Continuing education renewal course fee******		$((~~98.60~~)) 104.40
Continuing education classes provided by the department		$((~~12~~)) 12.70 per continuing education training hour $((~~8~~)) 8.45 per continuing education training hour for correspondence and internet courses

* Reciprocity application is only allowed for applicants that are applying work experience toward certification that was obtained in state(s) with which the department has a reciprocity agreement. The reciprocity application is valid for one year.

** The trainee certificate will expire one year from the date of issuance and must be renewed on or before the date of expiration. Trainee update fee required when hours are submitted outside of renewal period.

*** This fee applies to either the original issuance or a renewal of a certificate. If you have passed the plumbers certificate of competency examination or the medical gas piping installer endorsement examination and paid the certificate fee, you will be issued a plumber certificate of competency or a medical gas endorsement that will expire on your birth date.
The two-year renewal of a Medical Gas Piping Installer Endorsement must include a continuity affidavit verifying that brazing work has been performed every six months during the renewal cycle.

**** This fee is paid directly to a nationally recognized testing agency under contract with the department. It covers the cost of preparing and administering the written competency examination and the materials necessary to conduct the practical competency examination required for the medical gas piping system installers endorsement or the domestic pump or pump and irrigation examination. **This fee is not paid to the department.**

***** This fee is paid directly to a training course provider approved by the department, in consultation with the state advisory board of plumbers. It covers the cost of providing training courses required for the medical gas piping system installer endorsement. **This fee is not paid to the department.**

****** This fee is for a three-year period or code cycle.

******* The domestic pump specialty application is valid for one year.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-120 What do I need to know about plumber trainee certificates? General.

(1) **Journey level and specialty plumber original trainee certificates:**

The department will issue an original trainee certificate when the trainee applicant submits a complete trainee certificate application including:

(a) Date of birth, mailing address, Social Security number; and

(b) All appropriate fees as listed in WAC 296-400A-045.

(c) If an individual has previously held a plumbing trainee certificate, then that individual is not eligible for a subsequent original trainee certificate.

(d) All applicants for a plumbing trainee certificate must be at least sixteen years of age and must follow requirements as defined in WAC 296-125-030.

(2) Renewal.

(a) The department issues separate trainee certificates once a year.

(b) The plumbing trainee may not apply for renewal more than ninety days prior to the expiration date. Plumber trainee certificates are valid for one year.

(c) All applicants for trainee certificate of renewal must:

(i) Submit a complete renewal application;

(ii) Pay all appropriate fees; and

(iii) Completed the continuing education requirements described in chapter 296-400A WAC. Backflow trainees are exempt from continuing education requirements.

(d) If an individual files inaccurate or false evidence of continuing education information when renewing a plumbing trainee certificate, the individual's certificate may be suspended or revoked.

(e) An individual who has not completed the required hours of continuing education can renew a trainee certificate; however, the training certificate will be placed in an inactive status. The inactive training certificate will be returned to active status upon validation by the department of the required continuing education.

(f) If continuing education hours have not been met, trainee certificates will become expired/inactive and any plumbing work experience obtained by the trainee in expired/inactive status will not be credited.

(g) An individual may not renew a revoked trainee certificate.

(h) Apprentices registered in an approved program according to chapter 49.04 RCW who are obtaining classroom training consistent with the continuing education requirements under chapter 18.106 RCW and this chapter, as approved by the department, are deemed to have met the continuing education requirements necessary to renew a trainee certificate. Included under this exemption are active trainees that are not in the formal approved program according to chapter 49.04 RCW but are attending all hours of required classroom training along with the apprentices and meeting the work experience as required under chapter 18.106 RCW and this chapter. The plumber craft training school will be required to supply the department the necessary documentation to prove there was full hourly attendance of these trainees as is required of the apprentices while they attend the classroom training.

(i) The trainee will not be issued a renewal or reinstated training certificate if the individual owes the department money as a result of an outstanding final judgment.

(3) Ratio/supervision.

(a) Commercial/residential.

(i) A certified residential specialty plumber, residential service plumber, or domestic pump specialty plumber working on a commercial job site may work as a journey level trainee only if they have a current trainee certificate on their person while performing commercial plumbing work.

(ii) On a job site, the ratio of certified plumbers to plumbers trainees must be:

(A) One residential specialty plumber or journey level working on a residential plumbing job site may supervise no more than ((~~two~~)) three trainees. Supervision must be a minimum of seventy-five percent of the time spent on each and every job site.

(B) One journey level plumber working on a commercial job site may supervise no more than one trainee or one residential specialty plumber who holds a current trainee certificate. Supervision must be a minimum of seventy-five percent of the time spent on each and every job site.

(b) Domestic pump.

One appropriate domestic pump specialty plumber or one journey level plumber working on a domestic pump system may supervise no more than ((~~two~~)) three trainees. Supervision must be a minimum of seventy-five percent of the time spent on each and every job site.

(c) Medical gas.

A plumber trainee or specialty plumber who has a current trainee certificate with the state of Washington and has successfully completed or is enrolled in an approved medical gas piping installer training course may work on medical gas piping systems. Work may only occur when there is direct supervision by an active Washington state certified journey level plumber with an active medical gas piping installer endorsement issued by the department. Supervision must be one hundred percent of the time spent on each and every job site on a one-to-one ratio.

(d) Backflow.

A backflow specialty plumber, a journey level plumber on a commercial job site, or a residential specialty plumber on a residential job site must supervise one backflow trainee to perform maintenance and repair work on every backflow assembly on potable water systems inside every commercial or residential building. The ratio must be one to one for one hundred percent of the time on each and every job site.

(4) Affidavits of experience.

(a) At the time of renewal, the holder must provide the department with an accurate list of the holder's employers in the plumbing construction industry for the previous annual period. The individual must submit a completed, signed, and notarized affidavit(s) of experience. The affidavit of experience must accurately attest to:

(i) The plumbing installation work performed for each employer the individual worked for in the plumbing trade during the previous period;

(ii) The correct plumbing category the individual worked in; and

(iii) The actual number of hours worked in each category, worked under the proper supervision of a Washington certified journey level plumber, certified domestic pump specialty plumber, or residential specialty plumber.

(b) The trainee should ask each employer and/or apprenticeship-training director for an accurately completed, signed, and notarized affidavit of experience for the previous certification period. The employer(s) or apprenticeship training director(s) must provide the previous period's affidavit of experience to the individual within twenty days of the request.

(c) If hours for previous period are not submitted within the thirty days after renewing a plumbing training certificate, the individual may not receive credit for these previous period hours.

(d) Trainee hours will not be credited if the trainee owes outstanding penalties for violations of this chapter.

(e) Trainee hours will not be credited during periods of time when the trainee card is expired or inactive.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-121 What do I need to know about trainee experience and plumber examination requirements for the journey level and specialty plumber? (1) You may take the journey level examination after completing 8,000 hours and not less than four years of documented training which must include 4,000 hours of commercial plumbing experience under direct supervision of a certified journey level plumber.

(2) You may take the residential specialty plumber examination after completing 6,000 hours and not less than three years of documented training under direct supervision of a certified residential specialty or journey level plumber.

((~~(2) You may take the journey level examination after completing 8,000 hours and not less than four years of documented training which must include 4,000 hours of commercial plumbing experience under direct supervision of a certified journey level plumber.~~))

(3) You may take the residential service plumbing examination after completing 4,000 hours and not less than two years of documented training. The first year and 2,000 hours of supervision must be under direct supervision of a certified journey level or residential specialty plumber. The second year and 2,000 hours of trainee could be under a residential service plumber.

(4) For domestic pump specialty plumbers:

(a) To be eligible for a limited volume domestic pump specialty plumbers examination defined by RCW 18.106.010 ((~~(10)~~)) (14)(c), the trainee must complete 2,000 hours practical experience working under the direct supervision of a certified limited volume domestic pump specialty plumber, a certified unrestricted domestic pump specialty plumber, or a journey level plumber on pumping systems not exceeding one hundred gallons per minute. The experience may be obtained at the same time the individual is meeting the experience required by RCW 19.28.191, or equivalent experience may be accepted as determined by rule by the department in consultation with the advisory board. Restricted domestic pump specialty trainees who have completed at least 720 hours of on-the-job training and passed the competency examination required by WAC 296-400A-020 may work unsupervised for the remainder of the time required for work experience to become a restricted domestic pump specialty plumber.

(b) To be eligible for an unrestricted domestic pump specialty plumbers examination defined by RCW 18.106.010 ((~~(10)~~)) (14)(c), the trainee must complete 4,000 hours but not less than two years, of practical experience working under the direct supervision of a certified unrestricted domestic pump specialty plumber or a journey level plumber on pumping systems. The experience may be obtained at the same time the individual is meeting the experience required by RCW 19.28.191 or equivalent experience may be accepted as determined by rule by the department in consultation with the advisory board.

((~~(4)~~)) (5) To be eligible for a backflow assembly maintenance and repair specialty examination, the trainee must furnish written evidence that they have a valid backflow assembly tester certification administered and enforced by the department of health.

((~~(5)~~)) (6) Individuals are required to complete 16 hours of continuing education with a minimum of 4 hours of industry related electrical training prior to testing for journey level, domestic pump, or residential specialty plumber certification.

((~~(6)~~)) (7) Effective January 1, 2005, all plumber trainees will be required to meet the current hour requirements to test.

((~~(7)~~)) (8) **Apprentice/trade school endorsement requirements**. An individual who has a current journey level plumber, domestic pump specialty plumber, or residential specialty plumber trainee certificate and who has successfully completed or is currently enrolled in an approved apprenticeship program or in a technical school program in the plumbing construction trade in a school approved by the work force training and education coordinating board, may work without direct on-site supervision during the last six months of meeting the practical experience requirements of this chapter. In order to work without direct on-site supervision applicable to the type (residential or journey level) of training hours for which certification is being sought by the individual, this individual must obtain an apprentice/trade school trainee endorsement by submitting the applicable forms provided by the department and paying the applicable fees. This individual may work without direct on-site supervision until he or she receives the remaining hours required to be eligible to take the applicable examination. This individual may not supervise trainees. (See RCW 18.106.070.)

((~~(8)~~)) (9) **Any applicant** who fails an examination will be required to wait at least until the next scheduled examination date and location and work under the direct supervision of a certified plumber while holding an active trainee card, until they have passed the exam and their certificate of competency has been issued. Examinations are held the first Thursday of every month, unless that date falls on a holiday. Applications must be submitted and received by the plumbing certification program office two weeks before the next scheduled date.

((~~(9)~~)) (10) Failure to reschedule or appear on the scheduled exam date will result in forfeiture of the examination fee.

AMENDATORY SECTION (Amending WSR 10-06-051, filed 2/24/10, effective 4/1/10)

WAC 296-400A-300 What procedures does the department follow when issuing a notice of infraction? (1) If an authorized representative of the department determines that an individual has violated plumber certification requirements, including medical gas piping installer endorsement requirements, the department must issue a notice of infraction describing the reasons for the infraction.

(2) For plumber certification violations, the department may issue a notice of infraction to:

(a) An individual who is plumbing without a current plumber certificate; and

(b) The employer of the individual who is plumbing without a current plumber certificate; and

(c) The employer's authorizing agent or foreman that made the work assignment to the individual who is plumbing without a current plumber certificate; and

(d) An individual for not having their department issued certification card and governmental issued photo identification in their possession on the job site.

(3) For medical gas piping installer endorsement violations, the department may issue a notice of infraction to:

(a) An individual who is installing medical gas piping systems without a current plumber certificate and a current medical gas piping installer endorsement; and

(b) The employer of the individual who is installing medical gas piping systems without a current plumber certificate and a current medical gas piping installer endorsement; and

(c) The employer's authorizing agent or foreman that made the work assignment to the individual who is installing medical gas piping systems without a current plumber certificate and a current medical gas piping installer endorsement; and

(d) An individual for not having their department issued certification card and governmental issued photo identification in their possession on the job site.

(4) The department may issue an infraction to a contractor advertising or performing work under this chapter or chapter 18.27 RCW who is not properly registered under chapter 18.27 RCW.

(5) An individual may appeal a notice of infraction by complying with the appropriate provisions of RCW 18.106.-220.

(6) If good cause is shown, ((~~an administrative law judge~~)) the director may waive, reduce or suspend any monetary penalties resulting from the infraction.

(7) Any monetary penalties collected under this chapter, must be deposited in the plumbing certificate fund.

(8) The notice shall be accompanied by a certified check for two hundred dollars. The check shall be returned to the assessed party if the decision of the department is not sustained by the ALJ. If the ALJ sustains the decision of the department, the amount of the check shall be applied by the department.

AMENDATORY SECTION (Amending WSR 16-08-100, filed 4/5/16, effective 5/16/16)

WAC 296-400A-400 What are the monetary penalties for violating certification requirements? (1) A person cited for an infraction under chapter 18.106 RCW or this chapter will be assessed a monetary penalty based upon the following schedule:

(a) Individual or dispatcher

First Infraction	$((~~250.00~~)) 100.00
Second Infraction	$((~~500.00~~)) 200.00
Third Infraction	$((~~750.00~~)) 500.00
Fourth ((~~and each additional~~)) Infraction	((~~Not more than~~)) $1,000.00
Fifth Infraction	$2,000.00
Sixth Infraction	$4,000.00
Seventh and each additional infraction	Not more than $5,000.00

(b) Contractor ((~~or dispatcher~~))

First Infraction	$((~~250.00~~)) 500.00
Second Infraction	$((~~500.00~~)) 1,000.00
Third ((~~and each additional~~)) Infraction	((~~Not more than $1,000.00~~)) $2,000.00
Fourth Infraction	$4,000.00
Fifth and each additional infraction	Not more than $5,000.00

(2) Each day a person is in violation is considered a separate infraction.

(3) Each job site at which a person is in violation is considered a separate infraction.

(4) A warning for first-time violation of chapter 18.106 RCW and this chapter may be issued only once to an individual. Second or additional violations must be assessed a monetary penalty based on the escalating schedule; starting with the first infraction penalty amount under individual or dispatcher.

WSR 20-16-144
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed August 4, 2020, 1:48 p.m., effective September 4, 2020]

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

Purpose: Allows all state approved educator preparation programs to be eligible to serve as clock hour providers. This rule would allow approved preparation programs who are not able to issue credits to issue clock hours.

Citation of Rules Affected by this Order: Amending WAC 181-82-110.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Adopted under notice filed as WSR 20-12-057 on July 16, 2020 [May 29, 2020].

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 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: July 23, 2020.

Maren Johnson
Rules Coordinator

AMENDATORY SECTION (Amending WSR 14-20-051, filed 9/25/14, effective 10/26/14)

WAC 181-82-110 School district response and support for nonmatched endorsements to course assignment of teachers. (1) Individuals with initial, residency, endorsed continuing, ((~~or~~)) professional, or emergency teacher certificates who are employed with a school district under RCW 28A.405.210 may be assigned to classes other than in their areas of endorsement. If teachers are so assigned, the following shall apply:

(((~~(1)~~))) (a) A designated representative of the district and any such teacher so assigned shall mutually develop a written plan which provides for necessary assistance to the teacher, and which provides for a reasonable amount of planning and study time associated specifically with the out-of-endorsement assignment;

(((~~(2) Such teachers shall not be subject to nonrenewal or probation based on evaluations of their teaching effectiveness in the out-of-endorsement assignments;~~

~~(3)~~))) (b) Such teaching assignments shall be approved by a formal vote of the local school board for each teacher so assigned((~~;~~

~~(4)~~)).

(2) Special education preendorsement waiver:

(a) A teacher who has completed ((~~twenty-four quarter credit hours (sixteen semester credit hours)~~)) two hundred forty continuing education credit hours under WAC 181-85-030 of course work applicable to a special education endorsement shall be eligible for a preendorsement waiver from the special education office per chapter 392-172A WAC which will allow that person to be employed as a special education teacher.

(b) All remaining requirements for special education endorsement shall be completed within five years.

(3) Such teachers shall not be subject to nonrenewal or probation based on evaluations of their teaching effectiveness in the out-of-endorsement assignments under this section.