WSR 07-06-004
PERMANENT RULES
DEPARTMENT OF ECOLOGY

[Order 06-16—Filed February 22, 2007, 11:10 a.m., effective March 25, 2007]

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

Purpose: Ecology is making a technical correction to WAC 173-160-381 (3)(c), (d), (e) and (f), the standards for decommissioning dug wells. The error needs to be corrected to avoid confusion by those who will use the rule.

Citation of Existing Rules Affected by this Order: Amending WAC 173-160-381.

Statutory Authority for Adoption: Chapter 18.104 RCW.

Adopted under notice filed as WSR 07-01-110 on December 20, 2006.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 21, 2007.

Polly Zehm
for Jay J. Manning
Director

AMENDATORY SECTION (Amending Order 06-08, filed 11/21/06, effective 12/22/06)

WAC 173-160-381 What are the standards for decommissioning a well? Any well which is unusable, abandoned, or whose use has been permanently discontinued, or which is in such disrepair that its continued use is impractical or is an environmental, safety or public health hazard shall be decommissioned. The decommissioning procedure (as prescribed by these regulations) must be recorded and reported as required by the department.

(1) Cased wells. Remove all liners, debris, and obstructions from the well casing, except well screens and packers. All cased water wells shall be decommissioned in one of the following ways:

(a) Perforate the casing from the bottom to within five feet of the land surface and pressure seal the casing.

(i) Perforations shall be at least four equidistant cuts per row, and one row per foot. The perforations must be sufficient enough to allow neat cement grout or neat cement, or bentonite slurry to migrate outside the casing and effectively prevent the movement of water.

(ii) Apply enough pressure to force the sealing material through the perforations, filling any voids on the outside of the casing.

(iii) The casing shall be filled completely with neat cement grout, neat cement, or bentonite slurry. The screen and up to five feet of riser pipe may be filled with unhydrated bentonite. The remainder of the riser pipe must be removed.

(iv) The casing may be cut off at a maximum of five feet below land surface. A steel cap shall be welded on the casing; or

(b) Withdraw the casing and fill the bore hole with neat cement grout, neat cement, unhydrated bentonite, or bentonite slurry as the casing is being withdrawn.

(2) Uncased wells - Remove all liners, debris, and obstructions. Seal uncased wells with concrete, neat cement grout, neat cement, or bentonite.

(3) Dug wells -

(a) The following criteria are required for the decommissioning of all dug wells:

(i) Remove all debris and obstructions that impede decommissioning or that may contaminate the aquifer from within the dug well.

(ii) Dug wells may have a maximum of three feet of soil cover from top of sealing material to land surface.

(iii) Dug wells shall be sealed with either unhydrated bentonite, neat cement, neat cement grout, or concrete. The use of controlled density fill (CDF), bentonite slurry, or fly ash is prohibited.

(iv) Dug wells that are not cast-in-place must have a minimum of three feet of sealing material in contact with native soil below land surface. Bentonite slurry shall not be used to decommission dug wells.

(b) Dug wells that are dry at any time during the year and that are less than twenty feet in depth shall be sealed from the bottom to within three feet of land surface.

(c) Dug wells that have a static water level of ten feet from land surface or less and a depth of less than twenty feet may be decommissioned by installing clean chlorinated sand or pea gravel to a maximum depth of ten feet below land surface. ((~~Otherwise,~~)) The remainder of the well shall be filled with either unhydrated bentonite, neat cement, neat cement grout, or concrete.

(d) Dug wells that have a static water level over ten feet and a depth of less than twenty feet from land surface may be decommissioned by installing clean chlorinated sand or pea gravel to the static level. ((~~Otherwise,~~)) The remainder of the well shall be filled with either unhydrated bentonite, neat cement, neat cement grout, or cement.

(e) Dug wells with static levels twenty feet or less from the land surface and that are greater than twenty feet deep may be decommissioned by placing chlorinated sand or pea gravel to twenty feet below land surface. ((~~Otherwise,~~)) The remainder of the well, to a maximum of three feet below land surface, shall be filled with unhydrated bentonite, neat cement, neat cement grout, or concrete.

(f) Dug wells with static levels below twenty feet from land surface, may be decommissioned by placing chlorinated sand or pea gravel to the static level and then placing alternating layers of sealing material and chlorinated sand or pea gravel to within twenty feet of land surface. The alternating

layers of sand or pea gravel must be a maximum of five feet thick. The minimum thickness of the sealing material layers must be five feet. ((~~Otherwise,~~)) The remainder of the dug well shall be filled with unhydrated bentonite, neat cement, neat cement grout, or concrete to a maximum of three feet below land surface.

(4) Flowing artesian wells that are not leaking on the outside of the casing shall be decommissioned by pressure grouting with neat cement or weighted high solids bentonite slurry from the bottom of the well bore to land surface. If the well is leaking on the outside of the casing or if leaking develops while the decommissioning method above is employed, then the casing must be perforated and pressure grouted to replace all confining layers and to stop leakage.

(5) Placement of sealing material.

(a) Sealing material placed below the static water level shall be piped directly to the point of application or placed by means of a dump bailer or pumped through a tremie tube. As the sealing material is placed, the existing well tile may be encapsulated into the seal material. If concrete, neat cement grout, bentonite, bentonite slurry, or neat cement is used to seal below the static water level in the well, the material shall be placed from the bottom up by methods that avoid segregation or dilution of the material. When used to place concrete, neat cement, neat cement grout, or bentonite slurry the discharge end of the tremie tube shall be submerged in the sealing material to avoid breaking the seal while filling the annular space.

(b) All authorized sealing material placed above the static water level or into the dewatered portion of the well may be hand poured above the static water level, provided the material does not dilute or segregate, and result in a seal free of voids.

(c) When decommissioning wells that were originally constructed without casing, unhydrated bentonite chips or pellets may be hand placed, provided it forms a continuous seal.

WSR 07-06-005
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed February 22, 2007, 10:59 a.m., effective April 1, 2007]

Effective Date of Rule: April 1, 2007.

Purpose: The following sections were amended to correct references to chapter 296-841 WAC: WAC 296-848-20060 Exposure evaluations, 296-848-40020 Exposure controls, 296-855-20050 Exposure evaluations, and 296-855-40030 Exposure controls.

Citation of Existing Rules Affected by this Order: Amending WAC 296-848-20060 Exposure evaluations, 296-848-40020 Exposure controls, 296-855-20050 Exposure evaluations, and 296-855-40030 Exposure controls.

Statutory Authority for Adoption: RCW 49.17.010, 49.17.040, 49.17.050, 49.17.060.

Adopted under notice filed as WSR 07-01-079 on December 19, 2007 [2006].

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 4, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 4, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 22, 2007.

Judy Schurke
Acting Director

AMENDATORY SECTION (Amending WSR 05-17-168, filed 8/23/05, effective 1/1/06)

WAC 296-855-20050 Exposure evaluations.

IMPORTANT:

This section applies when there is a potential for airborne exposure to ethylene oxide (EtO) in your workplace.

When you conduct an exposure evaluation in a workplace where an employee uses a respirator, the protection provided by the respirator is not considered.

Following this section will also meet the requirements to identify and evaluate respiratory hazards found in ((~~another chapter, Respiratory hazards,~~)) chapter 296-841 WAC, Airborne contaminants.

You must:

• Conduct an employee exposure evaluation to accurately determine airborne concentrations of EtO by completing Steps one through seven of the exposure evaluation process, each time any of the following apply:

– No evaluation has been conducted.

– Changes have occurred in any of the following areas that may result in new or increased employee exposures:

■ Production.

■ Processes.

■ Personnel.

■ Exposure controls such as ventilation systems or work practices.

– You have any reason to suspect new or increased employee exposure may occur.

• Provide affected employees and their designated representatives an opportunity to observe any exposure monitoring during Step six of the exposure evaluation process.

• Make sure observers entering areas with EtO exposure:

– Are provided with and use the same protective clothing, respirators, and other personal protective equipment (PPE) that employees working in the area are required to use;

AND

– Follow all safety and health requirements that apply.

Exposure evaluation process

Step one: Identify all employees who have potential exposure to airborne ethylene oxide (EtO) in your workplace.

Step two: Identify operations where employee exposures could exceed EtO's fifteen-minute short-term exposure limit (STEL) of five parts per million (ppm).

Step three: Select employees from those working in the operations you identified in Step two who will have their STEL exposures measured.

Step four: Select employees from those identified in Step one who will have their eight-hour exposures monitored.

• Make sure the exposures of the employees selected represent eight-hour exposures for all employees identified in Step one including each job classification, work area, and shift.

• If you expect all employee exposures to be below the action level (AL), you can choose to limit your selection to those employees reasonably believed to have the highest exposures. If you find these employees' exposure to be above the AL, then you'll need to repeat Step four to represent all employees identified in Step one.

Note: You can use Steps three through six of this process to create a written description of the procedure used for obtaining representative employee exposure monitoring results, which is a requirement in Exposure records, WAC 296-855-20070.

Exemption: • You can skip Steps four through seven if you have documentation conclusively demonstrating that employee exposure for a particular material and the operation where it's used, cannot exceed the AL or STEL during any conditions reasonably anticipated.

• Such documentation can be based on observations, data, calculations, and previous air monitoring results. Previous air monitoring results:

– Must meet the accuracy required by Step five.

– May be from outside sources, such as industry or labor studies.

– Must be based on data that represents conditions being evaluated in your workplace.

Step five: Determine how you will obtain accurate employee exposure monitoring results. Select and use an air monitoring method with a confidence level of ninety-five percent, that's accurate to:

• ±twenty-five percent when concentrations are potentially above the AL or eight-hour time-weighted average of one part per million (ppm).

• ±thirty-five percent when concentrations are potentially above the AL of 0.5 ppm or the STEL of five ppm.

Note: Here are examples of air monitoring methods that meet this accuracy requirement:

• OSHA Method thirty found by going to: http://www.osha.gov/dts/sltc/methods/toc.html.

• NIOSH Method thirty eight hundred found by going to: http://www.cdc.gov./niosh/homepage.html and linking to the NIOSH Manual of analytical methods.

Step six: Obtain employee monitoring results by collecting air samples representing employees identified in Steps three and four.

• Collect STEL samples for employees and operations selected in Step three.

• Collect samples representing the eight-hour exposure, for at least one shift, for each employee selected in Step four.

• Make sure samples are collected from each selected employee's breathing zone.

Note: • You may use any sampling method that meets the accuracy specified in Step five. Examples of these methods include:

– Real-time monitors that provide immediate exposure monitoring results.

– Equipment that collects samples that are sent to a laboratory for analysis.

• The following are examples of methods for collecting samples representative of eight-hour exposures.

– Collect one or more continuous samples, such as a single eight-hour sample or four two-hour samples.

– Take a minimum of five brief samples, such as five fifteen-minute samples, during a work shift at randomly selected times.

• For work shifts longer than eight hours, monitor the continuous eight-hour portion of the shift expected to have the highest average exposure concentration.

Step seven: Have the samples you collected analyzed to obtain monitoring results for eight-hour and STEL exposures.

• Determine if employee exposure monitoring results are above or below the following values:

– Eight-hour time-weighted average (TWA_8) of one ppm.

– Fifteen-minute short-term exposure limit (STEL) of five ppm.

– Eight-hour action level (AL) of 0.5 ppm.

Note: • You may contact your local WISHA consultant for help:

– Interpreting data or other information.

– Determining eight-hour or fifteen-minute employee exposure monitoring results.

AMENDATORY SECTION (Amending WSR 05-17-168, filed 8/23/05, effective 1/1/06)

WAC 296-855-40030 Exposure controls.

IMPORTANT:

The use of an employee rotation schedule to control employee exposure to ethylene oxide (EtO) is prohibited.

Respirators and other personal protective equipment (PPE) are not exposure controls.

You must:

• Use feasible exposure controls to:

– Reduce exposure to, or below, the permissible exposure limit (PELs);

OR

– To reduce exposure to the lowest achievable level above the PELs.

((**~~Reference:~~** ~~Go to another chapter, Respiratory hazards, chapter 296-841 WAC for additional information on employee exposure controls.~~))

AMENDATORY SECTION (Amending WSR 05-01-173, filed 12/21/04, effective 5/1/05)

WAC 296-848-20060 Exposure evaluations.

IMPORTANT:

• This section applies when workplace operations create potential airborne exposure to inorganic arsenic.

• When you conduct an exposure evaluation in a workplace where an employee uses a respirator, the protection provided by the respirator is not considered.

• Following this section will fulfill the requirements to identify and evaluate respiratory hazards found in ((~~another chapter, Respiratory hazards,~~)) chapter 296-841 WAC, Airborne contaminants.

You must:

(1) Conduct an employee exposure evaluation to accurately determine airborne concentrations of inorganic arsenic by completing Steps 1 through 5 of the Exposure Evaluation Process, each time any of the following apply:

• No evaluation has been conducted.

• Changes have occurred in any of the following areas that may result in new or increased exposures:

– Production.

– Processes.

– Exposure controls such as ventilation systems or work practices.

– Personnel.

• You have any reason to suspect new or increased exposure may occur.

(2) Provide affected employees and their designated representatives an opportunity to observe exposure monitoring during Step 4 of the Exposure Evaluation Process.

• Make sure observers do not interfere with exposure measurements.

• Make sure observers are entitled to:

– An explanation of your exposure measurement and monitoring procedures;

– Observe all tasks of exposure measurement performed at the workplace;

AND

– Receive a copy of the exposure measurement results when you obtain them; or are allowed to record the exposure measurement results, if made during observations.

• Make sure observers who enter areas with inorganic arsenic exposure:

– Are provided with and use the same protective clothing, respirators, and other personal protective equipment (PPE) that employees working in the area are required to use;

AND

– Follow safety and health requirements that apply.

Exposure Evaluation Process

IMPORTANT:

Following the Exposure Evaluation Process is not necessary when you have documentation conclusively demonstrating inorganic arsenic exposures for a particular operation and material, cannot exceed the action level (AL) during any conditions reasonably anticipated. Documentation can be based on quantitative information such as soil test results OR qualitative information such as observations of how inorganic arsenic-containing materials are handled.

– Retain this documentation for as long as you rely on it.

Step 1: Identify all employees who have potential airborne exposure to inorganic arsenic in your workplace.

Step 2: Select employees from those identified in Step 1 who will have their eight-hour exposures monitored.

• Make sure the exposures of the employees selected represent eight-hour exposures for all employees identified in Step 1, including each job classification, work area, and shift.

Note: • A written description of the procedure used for obtaining representative employee exposure monitoring results needs to be kept as part of your exposure records required by this chapter in Exposure records, WAC 296-848-20090. This description can be created while completing Steps 2 through 4 of this exposure evaluation process.

Step 3: Determine how you'll obtain employee exposure monitoring results.

• Select and use a method that meets the following criteria for accuracy:

– ±25%, with a confidence level of 95%, when concentrations are potentially at or above an eight-hour time-weighted average of 10 micrograms per cubic meter ($\mu g/m^3$);

OR

– ±35%, with a confidence level of 95%, when concentrations are potentially between the eight-hour time-weighted averages of 5 $\mu g/m^3$ and 10 $\mu g/m^3$.

Note: • Here are examples of methods that meet this accuracy requirement:
– OSHA Method ID105 found by going to http://www.osha.gov/dts/sltc/methods/toc.html.
– NIOSH method 7901 found by going to http://www.cdc.gov/niosh/homepage.html and linking to the NIOSH Manual of Analytical Methods.

Step 4: Obtain employee exposure monitoring results by collecting air samples representing employees identified in Step 1.

• Sample at least one shift representative of the eight-hour exposure, for each employee selected in Step 2.

• Make sure samples are collected from each selected employee's breathing zone.

Note: • You may use any sampling method that meets the accuracies specified in Step 3. Examples of these methods include:
– Real-time monitors that provide immediate exposure monitoring results.
– Equipment that collects samples that are sent to a laboratory for analysis.
• The following are examples of methods for collecting samples representative of eight-hour exposures.
– Collect one or more continuous samples, for example, a single eight-hour sample or four two-hour samples.
– Take a minimum of 4 to 7 brief samples, such as fifteen-minute samples, during the work shift and at times selected randomly.
• For work shifts longer than eight hours, monitor the continuous eight-hour portion of the shift expected to have the highest average exposure concentration.

Step 5: Have the samples you collected analyzed to obtain monitoring results representing eight-hour exposures.

• Go to the Scope of this chapter, WAC 296-848-100, and compare employee exposure monitoring results to the values found in Step 1 and follow Step 2 to determine if additional sections of this chapter apply.

Note: • You may contact your local WISHA consultant for help:
– Interpreting data or other information.
– Determining eight-hour employee exposure monitoring results.

• To contact a WISHA consultant:

– Go to the Safety and health core rules, chapter 296-800 WAC;

AND

– Find the Resources section, and under "Other Resources," find *Service Locations for Labor and Industries*.

AMENDATORY SECTION (Amending WSR 05-01-173, filed 12/21/04, effective 5/1/05)

WAC 296-848-40020 Exposure controls.

IMPORTANT:

• Use of employee rotation to control exposures is not advisable since inorganic arsenic is a known carcinogen.

• Respirators and other personal protective equipment (PPE) do not substitute for feasible exposure controls.

You must:

• Use feasible exposure controls to reduce exposures to or below the permissible exposure limit (PEL), or as low as achievable.

((**~~Reference:~~** ~~To see examples of exposure controls go to Respiratory hazards, chapter 296-841 WAC, and find Table 1 in the section, Control employee exposure, WAC 296-848-20010.~~))

WSR 07-06-014
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2006-13—Filed February 26, 2007, 1:47 p.m., effective March 29, 2007]

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

Purpose: These amendments will correct technical errors in chapter 284-66 WAC.

Citation of Existing Rules Affected by this Order: Amending WAC 284-66-063, 284-66-066, 284-66-092, 284-66-142, and 284-66-160.

Statutory Authority for Adoption: RCW 48.06.060 and 48.66.165.

Adopted under notice filed as WSR 06-22-095 on February 12, 2007 [November 1, 2006].

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

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

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 5, 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: February 26, 2007.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-063 Benefit standards for policies or certificates issued or delivered after June 30, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(c) Each Medicare supplement policy must be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the Medicare supplement policy is terminated by the group policy holder and is not replaced as provided under (c)(v) of this subsection, the issuer must offer certificateholders an individual Medicare supplement policy that (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer must offer the certificateholder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(v) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(d) Termination of a Medicare supplement policy or certificate must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(e) If a Medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed renewal requirements of this section.

(f)(i) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) that the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to the assistance.

(ii) If the suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate must be automatically reinstituted effective as of the date of termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within ninety days after the date of the loss and pays the premium attributable to the period.

(iii) Each Medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy must be automatically reinstituted (effective as of the date of loss of coverage within ninety days after the date of the loss).

(g) Reinstitution of the coverages;

(i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(2) Standards for basic ("core") benefits common to benefit plans A-J. Every issuer must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in place of the basic "core" package.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of ((~~packaged~~)) packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital; outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(3) Standards for additional benefits. The following additional benefits must be included in Medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(a) Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A;

(c) Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the Medicare Part B excess charges: Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(e) One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by Medicare if provided in the United States and that began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (ii) of this subsection and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by the attending physician.

Reimbursement must be for the actual charges up to one hundred percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology (AMA CPT)* codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by Medicare.

(j) At-home recovery benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services that assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by Medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

((~~(3)~~)) (4) Standardized Medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(b) Coverage of one hundred percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must

accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (j) of this subsection;

(f) Hospice care: Coverage for fifty percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (j) of this subsection;

(g) Coverage for fifty percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

((~~(4)~~)) (5) Standardized Medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection ((~~(3)~~)) (4)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection ((~~(3)~~)) (4)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection ((~~(3)~~)) (4)(j) of this section but substituting two thousand dollars for four thousand dollars.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-066 Standard Medicare supplement benefit plans. (1) An issuer must make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as permitted in WAC 284-66-066(7) and in WAC 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit must be structured according to the format provided in WAC 284-66-063 (2), (3) ((~~or~~)), (4) or (5) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" must be limited to only the basic ("core") benefits common to all benefit plans, as defined in WAC 284-66-063(2).

(b) Standardized Medicare supplement benefit plan "B" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible as defined in WAC 284-66-063 (3)(a).

(c) Standardized Medicare supplement benefit plan "C" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized Medicare supplement plan "D" consists of only the following: The core benefit, as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized Medicare supplement benefit plan "E" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized Medicare supplement benefit plan "F" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized Medicare supplement benefit high deductible plan "F" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e) and (h) respectively. The annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services

covered by the Medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized Medicare supplement benefit plan "G" consists of only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (d), (h), and (j), respectively.

(i) Standardized Medicare supplement benefit plan "H" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (f), and (h), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(j) Standardized Medicare supplement benefit plan "I" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(k) Standardized Medicare supplement benefit plan "J" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(l) Standardized Medicare supplement benefit high deductible plan "J" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventative medical care benefit and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and must be in addition to any other specific benefit deductibles. The annual deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(6) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA):

(a) Standardized Medicare supplement benefit plan "K" consists of only those benefits described in WAC 284-66-063((~~(3)~~)) (4).

(b) Standardized Medicare supplement benefit plan "L" consists of only those benefits described in WAC 284-66-063((~~(4)~~)) (5).

(7) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefits may not include an outpatient prescription drug benefit.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-092 Form of "outline of coverage." (1) Cover page.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s)___[insert letter(s) of plan(s) being offered]

See Outlines of Coverage sections for details about ALL plans

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits for Plans A-J

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F/F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as plans F and J after one has paid a calendar year [$] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [$]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.
[Company Name] does not offer the [high deductible plan F] [high deductible plan J] [high deductible plan F or J].

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End
	50% Hospice cost-sharing	75% Hospice cost-sharing
	50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood
	50% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		

At-Home Recovery		
Preventative Care NOT covered by Medicare		
	$[ ] Out-of-Pocket Annual Limit***	$[ ] Out-of-Pocket Annual Limit***

**Plan K and L provide for different cost-sharing for items and services A-J.
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.
***The out-of-pocket annual limit will increase each year for inflation.
See Outlines of Coverage for details and exceptions.

(2) Disclosure page(s):

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts as noted in WAC 284-66-066(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(3) Charts displaying the feature of each benefit plan offered by the issuer:

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First 60 days	All but $[ ]	$0	$[ ] (Part A deductible)
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	$0	Up to $[ ] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	$0	Up to $[ ] a day

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	 $0 Generally 80% $0	 $0 Generally 20% $0	 $[ ] (Part B deductible) $0 All costs
BLOOD First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[ ] (Part B deductible) $0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[ ] (Part B deductible) $0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN C (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but $[ ] a day $0 $0	$[ ] a day 100% of Medicare eligible expenses $0	$0 $0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0 ((~~E~~))
- - - Durable medical equipment	$0	$0	$[ ] (Part B deductible)
First $[ ] of Medicare approved amounts*			
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN E
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN E (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE ((~~MEDICARE~~)) MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as plan F after one has paid a calendar year $[ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE, **] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN F (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE, **] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE, **] YOU PAY
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	((~~100~~)) 0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN H

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN H (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I (continued)
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year $[ ] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Parts A and B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year $[ ] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and B, but does not include the plan's separate foreign travel emergency deductible]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

[PLAN J] [HIGH DEDUCTIBLE PLAN J] (continued)

PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	$0	$0

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (❖) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[ ] (50% of Part A deductible)	$[ ] (50% of Part A deductible)✥
First 60 days	All but $[ ]		
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	Up to $[ ] a day✥
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%✥
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments✥

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts****	$0	$0	$[ ] (Part B deductible)****✥

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Preventative Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%✥
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[ ])*
BLOOD First 3 pints	$0	50%	50%✥
Next $[ ] of Medicare approved amounts****	$0	$0	$[ ] (Part B deductible)****✥
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%✥
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K (continued)

PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*****	$0	$0	$[ ] (Part B deductible)✥
Remainder of Medicare approved amounts	80%	10%	10%✥

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

*You will pay ((~~half~~)) <u>one-fourth</u> the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (✥) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION((~~*~~))**			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[ ] (75% of Part A deductible)	$[ ] (25% of Part A deductible)✥
First 60 days	All but $[ ]		
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE__*__**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	Up to $[ ] a day✥
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%✥
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	((~~75~~)) 25% of coinsurance or copayments✥

((~~*~~))NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*__****__Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts__****__	$0	$0	$[ ] (Part B deductible)****✥

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
Preventative Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%✥
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[ ])*
BLOOD			
First 3 pints	$0	75%	25%✥
Next $[ ] of Medicare approved amounts****	$0	$0	$[ ] (Part B deductible)****✥
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%✥
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L (continued)
PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts****((*))	$0	$0	$[ ] (Part B deductible)✥
Remainder of Medicare approved amounts	80%	15%	5%✥

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-142 Form of replacement notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE!
IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company name] Insurance Company. Your new policy will provide thirty days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other disability coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

. . . . Additional benefits.

. . . . No change in benefits, but lower premiums.

. . . . Fewer benefits and lower premiums.

. . . . My plan has outpatient prescription drug coverage and I am enrolling in Part D.

. . . . Disenrollment from a Medicare Advantage plan.

Please explain reason for disenrollment. [optional only for Direct Mailers]

. . . . Other. (please specify)

1. NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. If you have had your current Medicare supplement policy less than three months, health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

. . . . . .

(Signature of Agent, Broker, or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

. . . . . .

(Applicant's Signature)

. . . . . .

(Date)

*Signature not required for direct response sales.

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

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-160 Adjustment notice to conform existing Medicare supplement policies to changes in Medicare. As soon as practicable, but no later than thirty days before the effective date of any Medicare benefit changes, every ((~~insurer~~)) issuer providing Medicare supplement insurance coverage to a resident of this state must notify its insureds of modifications it has made to Medicare supplement policies. The adjustment notice is intended to be informational only and for the sole purpose of informing policyholders and certificate holders about changes in Medicare benefits, indexed deductible and copayment provisions, premium adjustments, and the like. The form of an adjustment notice provided to residents of this state must be filed with the commissioner before being used.

(1) The notice must include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy.

(2) The notice must inform each covered person of the approximate date when premium adjustments due to changes in Medicare benefits will be made.

(3) The notice of benefit modifications and any premium changes must be furnished in outline form and in clear and simple terms so as to facilitate comprehension.

(4) The notice must not contain or be accompanied by any solicitation.

(5) Issuers must comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

WSR 07-06-027

PERMANENT RULES

DEPARTMENT OF HEALTH

(Veterinary Board of Governors)

[Filed February 28, 2007, 1:43 p.m., effective March 31, 2007]

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

Purpose: The rules establish a clear definition of sexual misconduct for veterinary practitioners. The rules will help health care providers regulated by the veterinary board of governors avoid sexual misconduct and educate consumers about what should be expected from veterinary health care providers.

Statutory Authority for Adoption: RCW 18.92.030 and 18.130.050 (1), (12).

Adopted under notice filed as WSR 06-22-099 on November 1, 2006.

Changes Other than Editing from Proposed to Adopted Version: The language in proposed WAC 246-934-100 [(1)](g) was amended to clarify that the dating referred to in this section is dating of a romantic or sexual nature as opposed to arranging a date or meeting related to a business or practice matter.

A final cost-benefit analysis is available by contacting Judy Haenke, P.O. Box 47868, Olympia, WA 98594-7868 [98504-7868], phone (360) 236-4947, fax (360) 586-4359, e-mail judy.haenke@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 Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

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

Date Adopted: December 11, 2006.

Camilo O. de Guzman, DVM

Chair, Veterinary Board of Governors

Chapter 246-934 WAC

STANDARDS OF PROFESSIONAL CONDUCT

NEW SECTION

WAC 246-934-010 Purpose of chapter. The rules in this chapter define certain acts of unprofessional conduct for applicants or holders of licenses or registrations issued by the veterinary board of governors.

NEW SECTION

WAC 246-934-020 Definitions. (1) "Animal" means every creature, either alive or dead, other than a human being.

(2) "Board" means the veterinary board of governors.

(3) "Health care information" means any health care information, in any form that is associated with the key party, the patient or the health care of a patient.

(4) "Health care provider" means an individual applying for a credential or credentialed as a veterinary medication clerk, veterinary technician or veterinarian.

(5) "Key party" means persons who would be reasonably expected to play a significant role in the health care decisions for the patient and includes the owner, human companion, guardian, manager or trainer.

(6) "Legitimate health care purpose" means activities for examination, diagnosis, treatment, and personal care of patients, including palliative care, as consistent with community standards of practice for the profession. The activity must be within the scope of practice of the health care provider.

(7) "Patient" means an animal under the care and treatment of a health care provider.

(8) "Veterinary medication clerk" means a person who is registered under chapter 18.92 RCW to practice as a veterinary medication clerk.

(9) "Veterinary technician" means a person who is registered under chapter 18.92 RCW to practice as a veterinary technician.

(10) "Veterinarian" means a person who is licensed under chapter 18.92 RCW to practice veterinary medicine, surgery and dentistry in the state of Washington.

SEXUAL MISCONDUCT

NEW SECTION

WAC 246-934-100 Sexual misconduct. (1) A health care provider shall not engage, or attempt to engage, in sexual misconduct with a key party, inside or outside the health care setting. Key party initiation or consent does not excuse or negate the health care provider's responsibility. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes but is not limited to:

(a) Sexual intercourse;

(b) Touching the breasts, genitals, anus or any sexualized body part;

(c) Rubbing against a key party for sexual gratification;

(d) Kissing, touching, fondling or caressing of a romantic or sexual nature;

(e) Encouraging masturbation or other sex act in the presence of the health care provider;

(f) Masturbation or other sex act by the health care provider in the presence of the key party;

(g) Suggesting the possibility of a sexual or romantic dating relationship;

(h) Discussing the sexual history, preferences or fantasies of the health care provider;

(i) Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;

(j) Making statements regarding the key party's body, sexual history, or sexual orientation;

(k) Any verbal or physical contact which may reasonably be interpreted as sexually demeaning;

(l) Taking sexually explicit photographs or films of a key party;

(m) Showing a key party sexually explicit photographs.

(2) A health care provider shall not:

(a) Offer to provide health care services or professional knowledge in exchange for sexual favors;

(b) Use health care information to contact the key party for the purpose of engaging in sexual misconduct or to meet the health care provider's sexual needs.

(3) A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section with a former key party when:

(a) There is a significant likelihood that the key party will seek or require additional services from the health care provider; or

(b) The provider uses or exploits the trust, knowledge, influence or emotions derived from the professional relationship; or

(c) The health care provider uses or exploits privileged information or access to privileged information to meet the health care provider's sexual needs.

(4) When evaluating whether a health care provider is attempting to engage, or has engaged, in sexual misconduct, the board may consider factors, including but not limited to:

(a) Documentation of a formal termination and the circumstances of termination of the health care provider-patient relationship;

(b) Transfer of care to another health care provider;

(c) Duration of the health care provider-patient relationship;

(d) Amount of time that has passed since the last health care services were rendered to the patient;

(e) Communication between the health care provider and the key party between the last health care services rendered and commencement of the personal relationship;

(f) Nature of the patient's health condition during and since the professional relationship;

(g) The key party's emotional dependence and vulnerability; and

(h) Normal revisit cycle for the profession and service.

(5) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for legitimate health care purpose and that meets the standard of care appropriate to the profession; or

(c) Providing health care services for a legitimate health care purpose to an animal patient for a key party who is in a preexisting, established personal relationship with a health care provider where there is no evidence of, or potential for, exploiting the key party.

(6) Sexual conduct or sexual contact with an animal as defined in RCW 16.52.205 is unprofessional conduct. Violation of RCW 16.52.205 will be reported to the appropriate jurisdiction.

WSR 07-06-041
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed March 1, 2007, 2:37 p.m., effective April 1, 2007]

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

Purpose: The new and amended sections clarify and update policies for dental-related services for clients age twenty-one and older; ensure that department policies are applied correctly and equitably; replace the terms "medical assistance administration" and "MAA" with "the department"; update policy regarding prior authorization requirements; clarify policy on covered versus noncovered benefits; clarify additional benefits and limitations associated with those services for clients age twenty-one and older; and repeal WAC 388-535-1270 and 388-535-1290 and incorporate updated policy into new sections. Clients and dental providers will be able to identify the requirements and criteria that must be met in order to obtain covered dental-related services.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-535-1270 and 388-535-1290; and amending WAC 388-535-1050, 388-535-1065, 388-535-1255, and 388-535-1280.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.500, 74.09.520.

Adopted under notice filed as WSR 07-02-088 (part 1 of 4), 07-02-089 (part 2 of 4), 07-02-090 (part 3 of 4), and 07-02-091 (part 4 of 4) on January 3, 2007.

Changes Other than Editing from Proposed to Adopted Version: **Amended Sections:**

WAC 388-535-1247 (1) Subject to coverage limitations, ~~T~~the department pays for …when the services and procedures: …(d) Are documented in the client's record in accordance with chapter 388-502 WAC;

~~(d)~~ (e) Are within prevailing standard of care accepted dental or medical practice standards;

~~(e)~~ (f) Are consistent…;

~~(f)~~ (g) Are reasonable…; and

~~(g)~~ (h) Are listed…

WAC 388-535-1266 (1)(a) Requires prior authorization…In addition, the department requires the dental provider to ~~submit all the following~~: (i) Submit: (A) Appropriate and

diagnostic radiographs of all remaining teeth; ~~(ii)~~ (B) A dental record that identifies: ~~(A)~~ (I) All missing teeth for both arches; ~~(B)~~ (II) Teeth that are to be extracted; and ~~(C)~~ (III) Dental and periodontal services completed on all remaining teeth. ~~(iii)~~ (C) A prescription written …

(ii) Obtain a signed agreement of acceptance from the client at the conclusion of the final denture try-in for a department authorized complete denture or a cast-metal denture described in this section. If the client abandons the complete denture or the cast-metal partial denture after signing the agreement of acceptance, the department will deny subsequent requests for the same type dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement that documents the client's acceptance of the dental prosthesis must be submitted to the department's dental prior authorization section before the department pays the claim.

WAC 388-535-1267 (1)(h) Covers alveoloplasty: ~~(i) Only~~ only when three or more teeth are extracted per arch.; ~~and (ii) That is not performed in conjunction with extractions only on a case-by-case basis and when prior authorized.~~

A final cost-benefit analysis is available by contacting Dr. John Davis, P.O. Box 45506, Olympia, WA 98504-5506, phone (360) 725-1748, fax (360) 568-1590, e-mail davisjs@dshs.wa.gov.

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

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 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 9, Amended 4, 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 9, Amended 4, Repealed 2.

Date Adopted: February 27, 2007.

Robin Arnold-Williams
Secretary

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 07-07 issue of the Register.

WSR 07-06-042
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed March 1, 2007, 2:40 p.m., effective April 1, 2007]

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

Purpose: The new and amended sections clarify and update policies for dental-related services for clients through age twenty; ensure that department policies are applied correctly and equitably; replace the terms "medical assistance administration" and "MAA" with "the department"; update policy regarding prior authorization requirements; clarify policy on covered versus noncovered benefits; and clarify additional benefits and limitations associated with those services for clients through age twenty; clarify policy for the ABCD program; and repeal WAC 388-535-1200, 388-535-1230, and 388-535-1240 and incorporate updated policy into new sections. Clients and dental providers will be able to identify the requirements and criteria that must be met in order to obtain covered dental-related services.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-535-1200, 388-535-1230 and 388-535-1240; and amending WAC 388-535-1080, 388-535-1100, 388-535-1220, and 388-535-1245.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.500, 74.09.520.

Adopted under notice filed as WSR 06-24-069 (part 1 of 4), 06-24-068 (part 2 of 4), 06-24-071 (part 3 of 4), and 06-24-070 (part 4 of 4) on December 4, 2006.

Changes Other than Editing from Proposed to Adopted Version: **Note: Strikeouts and underlines indicate language deleted or added since the proposal.**

WAC 388-535-1079 Dental-related services for clients through age twenty—General. (1)(d) Are documented in the client's record in accordance with chapter 388-502 WAC;

~~(d)~~ (e) Are within…;

~~(e)~~ (f) Are consistent…;

~~(f)~~ (g) Are reasonable…; and

~~(g)~~ (h) Are listed…

(2) Under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program, clients ages twenty and younger may be eligible for ~~the~~ dental-related services listed as noncovered ~~in WAC 388-535-1100, if the services include those medically necessary services and other measures provided to correct or ameliorate conditions discovered during a screening performed under the EPSDT program~~.

WAC 388-535-1080 Covered dental-related services for clients through age twenty—Diagnostic. (1)(a) Oral health evaluations and assessments. ~~The services must be documented in the client's record in accordance with WAC 388-502-0020.~~

(2) **Radiographs (X-rays).** The department: …(f) Covers a maximum of ~~two~~ four bitewing radiographs once every twelve months for clients through age eleven.

WAC 388-535-1082 Covered dental-related services for clients through age twenty—Preventive services. (1)(a) Which includes scaling and polishing…once every six months for clients through age ~~eighteen~~ twenty. ~~(b) Which includes scaling and polishing procedures to remove coronal plague, calculus, and stains when performed on transitional or permanent dentition, once every twelve months for clients ages nineteen through twenty.~~

~~(c)~~ (b) Only when the service is performed six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ages thirteen through ~~eighteen~~ twenty.

~~(d) Only when the service is performed twelve months after periodontal scaling and root planing, or periodontal~~

~~maintenance services for clients ages nineteen through twenty.~~

~~(e)~~ (c) Only when not performed…scaling and root planing.

~~(f)~~ (d) For clients of the division of developmental disabilities…

(4)(d~~)~~ ~~Sealants only if evidence of occlusal or interproximal decay has not penetrated to the dentoenamel junction (DEJ).~~ Sealants on noncarious teeth or teeth with incipient caries.

WAC 388-535-1084 Covered dental-related services for clients through age twenty—Restorative services. (3) **Amalgam restorations for primary posterior teeth only.** The department~~: (a) C~~covers amalgam restorations for a maximum of two surfaces for a primary ~~posterior tooth~~ first molar and a maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this section for restorations for a primary posterior tooth requiring ~~a three or more surface restoration~~. additional surfaces.) The department does not pay for additional amalgam restorations. ~~(b) Does not pay for additional amalgam or composite restoration on the same tooth after two surfaces.~~

(6)(b) Resin-based composite restorations for a maximum of two surfaces for a primary ~~posterior tooth~~ first molar and a maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this subsection for restorations for a primary posterior tooth requiring ~~a three of [or] more surface restoration~~ additional surfaces.) The department does not pay for additional composite ~~or amalgon~~ restorations on the same tooth ~~after two surfaces~~.

(6)(c) Glass ionimer restorations only for primary teeth, and only for clients ages ~~four~~ five and younger…

(9)(c) Prefabricated stainless steel crowns for primary posterior teeth once every three years without prior authorization if~~:~~ ~~decay involves three or more surfaces, of if the tooth had a pulpotomy.~~ (i) Decay involves three or more surfaces for a primary first molar; (ii) Decay involves four or more surfaces for a primary second molar; or (iii) The tooth had a pulpotomy.

WAC 388-535-1090 Covered dental-related services for clients through age twenty—Prosthodontics (removable). (1)(f) Requires a provider to submit the following with a prior authorization request for removable prosthetics for a client residing in ~~a nursing home, group home, or other facility~~ an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility.

WAC 388-535-1098 Covered dental-related services for clients through age twenty—Adjunctive general services. (5)(a)(ii) Clients ages…when prior authorized; ~~and~~ (iii) Clients of the division of developmental disabilities according to WAC 388-535-1099~~.~~; and

(iv) Clients who reside in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility.

WAC 388-535-1100 Dental-related services not covered for clients through age twenty. (1)(a) The dental-related services described in subsection (2) of this section unless the services are covered ~~include those medically necessary services and other measures provided to correct or ameliorate conditions discovered during a screening performed~~ under the early periodic screening, diagnosis and treatment (EPSDT) program. See WAC 388-534-0100 for information about the EPSDT program.

A final cost-benefit analysis is available by contacting Dr. John Davis, P.O. Box 45506, Olympia, WA 98504-5506, phone (360) 725-1748, fax (360) 568-1590, e-mail davisjs@dshs.wa.gov.

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

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 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 11, Amended 4, Repealed 3.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 11, Amended 4, Repealed 3.

Date Adopted: February 27, 2007.

Robin Arnold-Williams
Secretary

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 07-08 issue of the Register.

WSR 07-06-043
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed March 1, 2007, 2:43 p.m., effective April 1, 2007]

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

Purpose: To comply with the requirements of the 2005 legislature, the department is adding new WAC 388-550-2650, to adopt two separate base community psychiatric hospital payments. One is for Medicaid clients and the other is for non-Medicaid clients. The new rule also clarifies that both Involuntary Treatment Act (ITA)-certified hospitals and hospitals that have ITA-certified beds that have been used to treat ITA patients are included in the base community psychiatric hospitalization payment method for Medicaid and non-Medicaid clients.

This permanent rule replaces the emergency rule filed under WSR 07-05-049. The amendment incorporates into rule that the department is adding certain newborn screening tests to the newborn metabolic screening panel and clarified that the department pays hospitals an additional flat fee to cover the cost of the tests; the amendment also clarifies language regarding inpatient payment methods and limits concerning inpatient hospital services for Medicaid clients.

Citation of Existing Rules Affected by this Order: Amending WAC 388-550-2800.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Other Authority: Part II, section 204, chapter 518, Laws of 2005 (ESSB 6090).

Adopted under notice filed as WSR 07-02-087 on January 3, 2007.

A final cost-benefit analysis is available by contacting Larry Linn, P.O. Box 45510, Olympia, WA 98504-5510, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.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 1, Amended 0, Repealed 0.

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

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

Date Adopted: February 27, 2007.

Robin Arnold-Williams
Secretary

NEW SECTION

WAC 388-550-2650 Base community psychiatric hospitalization payment method for Medicaid and non-Medicaid clients. (1) Effective July 1, 2005 and in accordance with legislative directive, the department implemented two separate base community psychiatric hospitalization payment rates, one for Medicaid clients and one for non-Medicaid clients. (For the purpose of this section, a "non-Medicaid client" is defined as a client eligible under the general assistance-unemployable (GA-U) program, the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), the psychiatric indigent inpatient (PII) program, or other state-administered program, as determined by the department.)

(a) The Medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to Medicaid covered patients, paid to hospitals that accept commitments under the involuntary treatment act (ITA).

(b) The non-Medicaid base community psychiatric hospital payment rate is a minimum allowable per diem for claims for psychiatric services provided to indigent patients paid to hospitals that accept commitments under the ITA.

(2) For the purposes of this section, "allowable" means the calculated amount for payment based on the payment method before adjustments, deductions, or add-ons.

(3) To be eligible for payment under the base community psychiatric hospitalization payment method:

(a) A client's inpatient psychiatric voluntary hospitalization must:

(i) Be medically necessary as defined in WAC 388-500-0005. In addition, the department considers medical necessity to be met when:

(A) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(B) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(C) The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; and

(D) The client, at the time of admission, is diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the current published Diagnostic and Statistical Manual of the American Psychiatric Association. The department does not consider detoxification to be psychiatric in nature.

(ii) Be approved by the professional in charge of the hospital or hospital unit.

(iii) Be authorized by the appropriate mental health division (MHD) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC 388-550-2600.

(b) A client's inpatient psychiatric involuntary hospitalization must:

(i) Be in accordance with the admission criteria in chapters 71.05 and 71.34 RCW.

(ii) Be certified by a MHD designee.

(iii) Be approved by the professional in charge of the hospital or hospital unit.

(iv) Be prior authorized by the regional support network (RSN) or its designee.

(v) Meet the criteria in WAC 388-550-2600.

(4) The provider requesting payment must complete the appropriate sections of the Involuntary Treatment Act Patient Claim Information (form DSHS 13-628) in triplicate and route both the form and each claim form submitted for payment, to the County Involuntary Treatment Office.

(5) Payment for all claims is based on covered days within a client's approved length of stay (LOS), subject to client eligibility and department-covered services.

(6) The Medicaid base community psychiatric hospitalization payment rate applies only to a Medicaid client admitted to a non-state-owned free-standing psychiatric hospital located in Washington state.

(7) The non-Medicaid base community psychiatric hospitalization payment rate applies only to a non-Medicaid client admitted to a hospital:

(a) Designated by the department as an ITA-certified hospital; or

(b) That has a department-certified ITA bed that was used to provide ITA services at the time of the non-Medicaid admission.

(8) For inpatient hospital psychiatric services provided to eligible clients on and after July 1, 2005, the department pays:

(a) A hospital's department of health (DOH)-certified distinct psychiatric unit as follows:

(i) For Medicaid clients, inpatient hospital psychiatric services are paid using the department-specific non-diagnosis related group (DRG) payment method.

(ii) For non-Medicaid clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-only DRG allowable (including the high cost outlier allowable, if applicable), or the department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system; or

(B) The non-Medicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(b) A hospital without a DOH-certified distinct psychiatric unit as follows:

(i) For Medicaid clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

(B) The department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system.

(ii) For non-Medicaid clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-only DRG allowable (including the high cost outlier allowable, if applicable), or the department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system; or

(B) The non-Medicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(c) A non-state-owned free-standing psychiatric hospital as follows:

(i) For Medicaid clients, inpatient hospital psychiatric services are paid using as the allowable, the greater of:

(A) The ratio of costs-to-charges (RCC) allowable; or

(B) The Medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(ii) For non-Medicaid clients, inpatient hospital psychiatric services are paid the same as for Medicaid clients, except the base community inpatient psychiatric hospital payment rate is the non-Medicaid rate, and the RCC allowable is the state-only RCC allowable.

(d) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the certified public expenditure (CPE) payment program, as follows:

(i) For Medicaid clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650.

(ii) For non-Medicaid clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650 in conjunction with the non-Medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(e) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the critical access hospital (CAH) program, as follows:

(i) For Medicaid clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

(ii) For non-Medicaid clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

AMENDATORY SECTION (Amending WSR 05-12-022, filed 5/20/05, effective 6/20/05)

WAC 388-550-2800 ((~~Inpatient~~)) Payment methods and limits-Inpatient hospital services for Medicaid clients. The term "allowable" used in this section means the calculated amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

(1) The department ((~~reimburses~~)) pays hospitals for Medicaid inpatient hospital services using the rate setting methods identified in the department's approved state plan ((~~that includes~~)) as follows:

((~~Method~~)) Payment method used for Medicaid inpatient hospital claims	((~~Used for~~)) Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
((~~Diagnoses~~)) Diagnosis related group (DRG) negotiated conversion factor	Hospitals participating in the Medicaid hospital selective contracting program under waiver from the federal government	Lesser of either the DRG billed amount minus the third-party payment and any client responsibility amount, or the allowable, minus the third-party payment amount and any client responsibility amount.
DRG cost-based conversion factor	Hospitals not participating in or exempt from the Medicaid hospital selective contracting program	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowable, minus the third-party payment amount and any client responsibility amount.
Ratio of costs-to-charges (RCC)	Hospitals or services exempt from DRG payment methods	The allowable minus the third-party payment amount and any client responsibility amount.

((~~Method~~)) Payment method used for Medicaid inpatient hospital claims	((~~Used for~~)) Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Costs-to-charges rate with a "hold harmless" settlement provision	Hospitals eligible to be paid through the certified public expenditure (CPE) payment program	The allowable minus the third-party payment amount and any client responsibility amount. The payment made is the federal share only.
Single case rate	((~~Bariatric surgery~~)) Hospitals eligible to provide bariatric surgery to medical assistance clients	Single case rate minus the third-party payment amount and any client responsibility amount.
Fixed per diem rate	((~~Acute physical medicine and rehabilitation (Acute PM&R) Level B facilities and~~)) Long-term acute care (LTAC) hospitals	Per diem amount minus the third-party payment amount and any client responsibility amount.
Cost settlement	((~~MAA~~)) DOH-approved critical access hospitals (CAHS)	The allowable times the approved CAH rate, subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount.
Medicaid base community psychiatric hospitalization rate	Non-state-owned free-standing psychiatric hospitals located in Washington state	Paid according to applicable payment method in WAC 388-550-2650 for Medicaid clients, minus the third-party payment amount and any client responsibility amount.

See WAC 388-550-4800 for payment methods used by the department for inpatient hospital services provided to clients eligible under state-administered programs.

(2) The department's annual aggregate Medicaid payments to each hospital for inpatient hospital services provided to Medicaid clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR ((~~§~~)) Sec. 447.271). The department recoups annual aggregate Medicaid payments that are in excess of the usual and customary charges.

(3) The department's annual aggregate payments for inpatient hospital services, including state-operated hospitals, will not exceed the estimated amounts that the department would have paid using Medicare payment principles.

(4) When hospital ownership changes, the department's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(5) Hospitals participating in the department's medical assistance program must annually submit to the ((~~medical assistance administration~~)) department:

(a) A copy of the hospital's ((~~HCFA 2552~~)) CMS Medicare Cost Report (form 2552-96) that is the official "as submitted" cost report submitted to the Medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 388-550-4900 for the requirement for a hospital to qualify for a DSH payment.

(6) Reports referred to in subsection (5) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by ((~~MAA~~)) the department.

(7) The department requires hospitals to follow generally accepted accounting principles ((~~unless federally or state regulated~~)).

(8) Participating hospitals must permit the department to conduct periodic audits of their financial ((~~and~~)) records, statistical records, and any other records as determined by the department.

(9) ((~~The department reimburses hospitals for claims involving clients with third-party liability insurance:~~

~~(a) At the lesser of either the DRG:~~

~~(i) Billed amount minus the third-party payment amount; or~~

~~(ii) Allowed amount minus the third-party payment amount; or~~

~~(b) The RCC allowed payment minus the third-party payment amount~~)) The department limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(10) For a client's hospital stay that involves both Regional Support Network (RSN)-approved voluntary inpatient and involuntary inpatient hospitalizations, the hospital must bill the department for payment, unless the hospital contracts directly with the RSN. In that case, the hospital must bill the RSN for payment.

(11) The department pays hospitals to cover the cost of certain newborn screening tests that are required under chapter 70.83 RCW (see also chapter 246-650 WAC). The flat fees that are not included in the DRG rate but are related to performing the newborn screening tests are added to the DRG payment. Hospitals are responsible to bill for all new-

born screening fees when submitting any claims for newborn services to the department.

(12) Refer to subsection (1) of this section for how the department adjusts inpatient hospital claims for third party payment amounts and any client responsibility amounts.

WSR 07-06-047
PERMANENT RULES
DEPARTMENT OF AGRICULTURE
[Filed March 1, 2007, 3:20 p.m., effective April 1, 2007]

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

Purpose: Chapter 16-409 WAC, Washington standards for asparagus, adopts modified United States fresh asparagus standards for U.S. grades No. 1 and No. 2, and sets the standards by which asparagus grown in Washington is graded and packaged for sale. The proposed amendments are necessary to bring these standards in line with other states and countries, thereby increasing sales and marketing opportunities for growers, packers, and shippers.

Citation of Existing Rules Affected by this Order: Amending WAC 16-409-020, 16-409-022, 16-409-024, 16-409-026, 16-409-030, 16-409-035, 16-409-065, and 16-409-070.

Statutory Authority for Adoption: Chapters 15.17 and 34.05 RCW.

Adopted under notice filed as WSR 07-01-106 on December 19, 2006.

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

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 5, Repealed 0.

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 8, Repealed 0.

Date Adopted: March 1, 2007.

Valoria Loveland
Director

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-020 ((~~What~~)) Standards that apply to all asparagus marketed within Washington state((~~?~~)). Any lot of fresh asparagus, including "culls," marketed within Washington state must have no more than ten percent of the stalks that((~~:~~

~~(1)~~)) have white in excess of two inches((~~; and~~

~~(2) Are less than 4/16 inch in diameter~~)).

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-022 ((~~What grades are used to identify asparagus in Washington state?~~)) Asparagus grades. (1) The following table identifies and describes the asparagus grades used in Washington state:

Washington Asparagus Grades:						
Stalk Characteristics:		**"Extra Fancy Grade Asparagus"**	**"Extra Fancy Grade Asparagus Tips"**	**"Fancy Grade Asparagus"**	**"Consumer Pack Asparagus"**	**"Culls"**
Stalks must be:						
(a)	Clean;	Yes	Yes	Yes	Yes	No
(b)	Fresh;	Yes	Yes	Yes	Yes	No
(c)	Fairly uniform in length;	Yes	Yes	Yes	Yes	No
(d)	Well trimmed;	Yes	Yes	No	No	No
(e)	Fairly well trimmed;	No	No	Yes	Yes	No
(f)	Fairly straight;	Yes	Yes	No	Yes	No
(g)	Not wilted;	Yes	Yes	Yes	Yes	No
(h)	Not badly misshapen;	No	No	Yes	No	No
(i)	Free from decay;	Yes	Yes	Yes	Yes	No
(j)	Free from damage caused by spreading or broken tips, dirt, disease, insects, or mechanical or other means;	Yes	Yes	Yes	Yes	No
(k)	At least eighty-five percent green in color;	Yes	No	Yes	Yes	No

Washington Asparagus Grades:					
Stalk Characteristics:	**"Extra Fancy Grade Asparagus"**	**"Extra Fancy Grade Asparagus Tips"**	**"Fancy Grade Asparagus"**	**"Consumer Pack Asparagus"**	**"Culls"**
Stalks must be:					
(l) All green.	No	Yes	No	No	No

(2) "Culls" describes asparagus that:

(a) Is not graded in conformity with Washington extra fancy, Washington extra fancy tips, Washington fancy, Washington consumer pack, or U.S. No. 1, or U.S. No. 2; and

(b) Must not be marketed if more than ten percent by count of the stalks show white in excess of two inches.

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-024 ((~~What are the~~)) Size requirements for Washington asparagus grades((~~?~~)). The following ((~~table identifies asparagus~~)) size ((~~requirements by Washington grades:~~)) designations apply to all grades of asparagus in Washington state.

((~~Washington Asparagus Grades~~	~~Stalks within individual containers must meet one of the following designated sizes:~~	~~Grade lots must be designated as:~~	~~Ninety percent, by count, of the stalks in any lot must conform to the diameters for such designations:~~
~~"Extra Fancy Grade Asparagus"~~	~~Jumbo~~	~~Washington extra fancy jumbo or Washington jumbo~~	~~Washington extra fancy jumbo or Washington jumbo must have stalks at least 13/16 inch in diameter.~~
	~~Large~~	~~Washington extra fancy large or Washington large~~	~~Washington extra fancy large or Washington large must have stalks at least 7/16 inch in diameter.~~
	~~Standard~~	~~Washington extra fancy standard or Washington standard~~	~~Washington extra fancy standard or Washington standard must have stalks at least 6/16 inch in diameter.~~
~~"Extra Fancy Grade Asparagus Tips"~~	~~Jumbo~~	~~Washington extra fancy tips jumbo~~	~~Washington extra fancy tips jumbo must be 13/16 inch in diameter or larger.~~
	~~Large~~	~~Washington extra fancy tips large~~	~~Washington extra fancy tips large must be 7/16 inch in diameter or larger.~~
	~~Standard~~	~~Washington extra fancy tips standard~~	~~Washington extra fancy tips standard must be 6/16 inch in diameter or larger.~~
	~~Small~~	~~Washington extra fancy tips small~~	~~Washington extra fancy tips small must have a diameter of at least 4/16 inch.~~
~~"Fancy Grade Asparagus"~~	~~Small~~	~~Minimum diameter; or Washington fancy small or Washington small~~	~~Washington fancy grade asparagus lots must be designated by minimum diameter. However, when at least ninety percent, by count, of the stalks in any lot are at least 4/16 inch in diameter, the lot may be designated as Washington fancy small or Washington small.~~

((~~Washington Asparagus Grades~~	~~Stalks within individual containers must meet one of the following designated sizes:~~	~~Grade lots must be designated as:~~	~~Ninety percent, by count, of the stalks in any lot must conform to the diameters for such designations:~~
~~"Washington consumer pack"~~	~~N/A~~	~~Washington consumer pack~~	~~Washington consumer pack lots must be designated by minimum diameter and stalks must be at least 4/16 inch in diameter.~~
~~"U.S. No. 1 grade"~~	~~N/A~~	~~Minimum diameter; or~~	~~N/A~~
	~~Jumbo~~	~~Washington jumbo~~	~~U.S. No. 1 grade jumbo must have stalks at least 13/16 inch in diameter.~~
	~~Large~~	~~Washington large~~	~~U.S. No. 1 grade large must have stalks at least 7/16 inch in diameter.~~
	~~Standard~~	~~Washington standard~~	~~U.S. No. 1 grade standard must have stalks at least 6/16 inch in diameter.~~
~~"U.S. No. 2 grade"~~	~~N/A~~	~~Minimum diameter; or~~	~~N/A~~
	~~Small~~	~~Washington small~~	~~U.S. No. 2 grade small must have stalks at least 4/16 inch in diameter.~~))

(1) Jumbo: Stalks at least 13/16 inch in diameter.
(2) Extra large: Stalks at least 10/16 inch in diameter.
(3) Large: Stalks at least 7/16 inch in diameter.
(4) Standard: Stalks at least 5/16 inch in diameter.
(5) Small: Stalks less than 5/16 inch in diameter.
(6) All size designations, as defined in WAC 16-409-024, may be packed in all grades and in all containers.

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-026 ((~~Does the department adopt~~)) Adoption of U.S. standards for fresh asparagus as Washington state standards((~~?~~)). (1) In addition to the Washington state fresh asparagus standards contained in this chapter, the Washington state department of agriculture has adopted, as Washington state standards, modified United States fresh asparagus standards for U.S. grades No. 1 and No. 2.

(2) The department's modifications to the U.S. standards are as follows:

(a) U.S. No. 1 must ((~~be at least 6/16 inch in diameter and must~~)) meet or exceed Washington extra fancy grade requirements.

(b) U.S. No. 2 must ((~~be at least 4/16 inch in diameter and must~~)) meet or exceed Washington fancy grade requirements.

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-030 ((~~What~~)) Tolerances ((~~are adopted for Washington asparagus?~~)). The following table identifies and explains the tolerances adopted for Washington asparagus:

Washington Asparagus Grades to Which Tolerances Apply	Defect, color and trim tolerances adopted for Washington asparagus	Diameter and length tolerances adopted for Washington asparagus
Washington extra fancy Washington extra fancy tips Washington fancy Washington consumer pack	To allow for variations incident to proper grading and handling, the following tolerances are adopted:	To allow for variations in diameter and length incident to proper sizing, the following tolerances are adopted:
	(1) Ten percent, by count, for stalks failing to meet grade requirements other than for trim and color, including no more than one percent for decayed stalks.	(1) Ten percent, by count, for stalks failing to meet the required minimum and maximum diameter defined in WAC 16-409-015 ("fairly uniform in length").

Washington Asparagus Grades to Which Tolerances Apply	Defect, color and trim tolerances adopted for Washington asparagus	Diameter and length tolerances adopted for Washington asparagus
	(2) An additional ten percent, by count, for stalks having less than the required amount of green color.	(2) Ten percent, by count, for stalks failing to meet the required length as established in WAC 16-409-022.
	(3) An additional ten percent, by count, for stalks not meeting trim requirements.	

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-035 ((~~How does the department apply its~~)) Application of asparagus tolerances during an inspection((~~?~~)). (1) If the averages for an entire lot are within the tolerances specified in WAC 16-409-030, the limitations in this section, based upon sample inspections, apply to the contents of individual containers in the lot.

(2) Individual containers:

(a) May contain one decayed or otherwise defective stalk, one poorly trimmed stalk, one poorly colored, and one off-size stalk.

(b) Must have no more than one and one-half times the tolerance specified when a tolerance is ten percent or more.

(c) Must have no more than double the tolerance specified when a tolerance is less than ten percent.

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-065 ((~~What~~)) Container requirements ((~~apply to the containers used to market fresh asparagus?~~)). ((~~The following table identifies and explains the requirements that apply to the containers used to market fresh asparagus:~~

~~Asparagus Grades:~~	~~Container Requirements:~~
~~(1) All fresh asparagus:~~	~~Must be marketed in containers that are clean and free from dirt, trash, and visible contaminates.~~
~~(2) All fresh asparagus:~~	~~Must not be marketed in field containers.~~
~~(3) For testing or trial marketing purposes, the director:~~	~~May allow the use of any experimental containers not specified in this table.~~
~~(4) Washington extra fancy, Washington extra fancy tips, Washington fancy, U.S. No. 1, and U.S. No. 2 grades of fresh asparagus:~~	~~Must be marketed in containers with moisture pads.~~
~~(5) Washington consumer pack grade of fresh asparagus:~~	~~Must be marketed either in:~~ ~~(a) Pyramid type containers with moisture pads; or~~ ~~(b) Fiberboard or wooden "western lug" containers with:~~ ~~(i) Inside dimensions of approximately seven inches, by eleven and one-half inches, by eighteen inches; or~~ ~~(ii) A capacity of thirteen hundred and fifty to fifteen hundred and fifty cubic inches.~~ ~~(iii) Western lugs must contain at least twenty pounds net weight.~~
~~(6) Culls;~~	~~Must be marketed in wooden pyramid containers with moisture pads.~~))

(1) All fresh asparagus must be marketed in containers that are clean and free from dirt, trash, and visible contaminates.

(2) All fresh asparagus must not be marketed in field containers.

(3) For testing or trial marketing purposes, the director may allow the use of any experimental container.

(4) Culls must be marketed in wooden pyramid containers with moisture pads.

(a) Name and address of the grower, packer, or distributor;

AMENDATORY SECTION (Amending WSR 05-10-092, filed 5/4/05, effective 6/4/05)

WAC 16-409-070 ((~~What~~)) Container marking requirements ((~~apply to fresh asparagus containers?~~)). (1) All required markings must be placed on one end of the container, but may be duplicated on the opposite end.

(2) Containers must be conspicuously and legibly marked with the:

(b) Grade;

(c) Net weight; and

(d) Size designation or diameter size as defined in WAC 16-409-024.

(3) The grade and size designation required in subsection (2) of this section must be marked in letters at least 3/8 inch in height.

(4) The following abbreviations of grade and size designation are acceptable:

(a) Washington as Wash. or WA.

(b) Extra fancy as ex fcy or extra fcy.

(c) Fancy as fcy.

(d) Jumbo as jbo.

(e) Extra large as ex lge.

(f) Large as lge.

((~~(e)~~)) (g) Standard as std.

(h) Small as sm.

(5) The use of U.S. No. 1 or U.S. No. 2 grade markings is permissible subject to the requirements in WAC 16-409-026.

(6) If culls are marketed:

((~~(a)~~)) The word "culls" must be:

((~~(i)~~)) (a) Conspicuously and legibly marked in letters at least one inch in height; and

((~~(ii)~~)) (b) Predominant in size over any other markings on the container.

((~~(b) They must be marketed only in wooden pyramid containers with moisture pads.~~))

WSR 07-06-050
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
(Mental Health Division)
[Filed March 2, 2007, 10:46 a.m., effective April 2, 2007]

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

Purpose: This rule would expand the options for intake evaluation to allow for an abbreviated process for intake evaluation when the individual is expected to need short-term mental health services, or had full evaluation previously and is resuming services.

Citation of Existing Rules Affected by this Order: Amending WAC 388-865-0420.

Statutory Authority for Adoption: RCW 71.24.035.

Adopted under notice filed as WSR 06-22-089 on November 1, 2006.

Changes Other than Editing from Proposed to Adopted Version: (1) ~~Each consumer requesting services must receive an intake evaluation.~~ The intake evaluation or brief intake evaluation must be provided by a Mental Health Professional and:

(4)(h) Identification of mutually agreed upon outcomes that are expected to be accomplished within the six-month period that will be ~~the basis of~~ the treatment plan. This treatment plan will be used in place of the treatment plan required in WAC 388-865-0425.

(5) In cases where a consumer initially receives services based on a brief intake evaluation, the community support service provider must complete the additional elements required in a full intake evaluation if the consumer is expected to continue to receive services after six months. In these cases a treatment plan must be developed that meets all the requirements of WAC 388-865-0425.

A final cost-benefit analysis is available by contacting Melena Thompson, P.O. Box 45320, Olympia, WA 98504-5320, phone (360) 902-0840, fax (360) 902-0809, e-mail thompml@dshs.wa.gov.

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

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 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: March 2, 2007.

Robin Arnold-Williams
Secretary

AMENDATORY SECTION (Amending WSR 05-14-082, filed 6/30/05, effective 7/31/05)

WAC 388-865-0420 Intake evaluation. ((~~The community support service provider must complete an intake evaluation in collaboration with the consumer within fourteen days of admission to service. If seeking this information presents a barrier to service, the item may be left incomplete provided that the reasons are documented in the clinical record. The following must be documented in the consumer's intake evaluation:~~

~~(1) A consent for treatment or copy of detention or involuntary treatment order;~~

~~(2) Consumer strengths, needs and desired outcomes in their own words. At the consumer's request also include the input of people who provide active support to the consumer;~~

~~(3) The consumer's age, culture/cultural history, and disability;~~

~~(4) History of substance use and abuse or other co-occurring disorders;~~

~~(5) Medical and mental health services history and a list of medications used;~~

~~(6) Documentation that consumers receiving court ordered treatment or treatment ordered by the department of corrections (DOC) have been asked if they are under supervision by the department of corrections. The consumer is required to disclose this information.~~

~~(7) For children:~~

~~(a) Developmental history; and~~

~~(b) Parent's goals and desired outcomes.~~

~~(8) Sufficient information to justify the diagnosis;~~

~~(9) Review of the intake evaluation by a mental health professional~~)) (1) The intake evaluation or brief intake evaluation must be provided by a Mental Health Professional and:

(a) Be initiated prior to the provision of any non-crisis mental health services;

(b) Be initiated within ten working days of the request for services;

(c) Be developed in collaboration with the consumer;

(d) Be inclusive of input of people who provide active support to the consumer, if the consumer requests or if the consumer is under age thirteen;

(e) Be completed within thirty working days of the initiation of the intake evaluation; and

(f) Include a consent for treatment or a copy of detention or involuntary treatment order.

(2) Except as when a brief intake evaluation as described in WAC 388-865-0420(4) is provided, a full intake evaluation must include:

(a) A description of the presenting problem, presented needs;

(b) A description of the consumer's and family's strengths;

(c) Consumer's needs and desired outcomes in the consumer's own words;

(d) Consumer's culture/cultural history (including, but not limited to, ethnicity or race, and religion);

(e) History of other disorders, substance/alcohol abuse, developmental disability, any other relevant disability, and treatment, if any;

(f) Medical history, hospitalizations, treatment, past and current medications;

(g) Mental health services history, past and current medication;

(h) Assessment of suicide/homicide and self harm risk. A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, must be made if indicated in the risk assessment;

(i) Sufficient information to justify the provisional diagnosis;

(j) Documentation showing the consumer has been asked if they are under the supervision of the department of corrections or juvenile court;

(k) If the consumer is a child:

(i) Developmental history;

(ii) Parental goals and desired outcomes (if consent is obtained or not required due to age or state custody); and

(iii) Family and/or placement issues, including, if appropriate, family dynamics, placement disruptions, and current placement needs.

(3) If seeking any of the information required in subsection (2) of this section presents a barrier to the provision of services for the consumer, any portion of the intake may be left incomplete providing the reason for the omission is clearly documented in the clinical record.

(4) A brief intake evaluation may be used when it is reasonably believed services to the consumer will be completed within a six-month period. A brief intake evaluation may also be substituted for a full intake evaluation if a consumer is resuming services after being out of services for a period of less than twelve months and had received a full intake evaluation as part of the previous service provision. A brief intake evaluation must include:

(a) A description of presenting problem, presented needs, desired outcomes, and consumer strengths identified by both the consumer and the clinician;

(b) Sufficient information to justify the provisional diagnosis;

(c) The consumer's current physician and prescribed medications;

(d) Current and historical substance use/abuse or other co-occurring disorders including developmental disabilities;

(e) Mental health services history including past and current medications;

(f) Assessment of suicide/homicide and self-harm risk. A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, must be made if indicated in the risk assessment;

(g) Documentation that the consumer has been asked if they are under the supervision by the department of corrections or juvenile court; and

(h) Identification of mutually agreed upon outcomes that are expected to be accomplished within the six-month period that will be the treatment plan. This treatment plan will be used in place of the treatment plan required in WAC 388-865-0425.

(5) In cases where a consumer initially receives services based on a brief intake evaluation, the community support service provider must complete the additional elements required in a full intake evaluation if the consumer is expected to continue to receive services after six months. In these cases a treatment plan must be developed that meets all the requirements of WAC 388-865-0425.

(6) If seeking any of the information required in subsection (4) of this section presents a barrier to the provision of services for the consumer, any portion of the intake may be left incomplete providing the reason for the omission is clearly documented in the clinical record.

WSR 07-06-053

PERMANENT RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Economic Services Administration)

(Division of Child Support)

[Filed March 2, 2007, 12:51 p.m., effective April 2, 2007]

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

Purpose: The division of child support (DCS) seeks to clarify the rules regarding the establishment of administrative child support orders. DCS believes that the statutory authority contained in chapter 74.20A RCW concerning the establishment of administrative child support orders does not give DCS the authority to establish child support orders which set off one parent's child support obligation against the other in the manner established in *Marriage of Arvey,* 77 Wn. App. 817, 894 P.2d 1346 (1995). DCS wishes to clarify that such

set off should not be used in administrative child support orders entered by administrative law judges, either.

Citation of Existing Rules Affected by this Order: Amending WAC 388-14A-3200 and 388-14A-6300.

Statutory Authority for Adoption: RCW 74.08.090, 34.05.220 (1)(a), 74.20A.055.

Adopted under notice filed as WSR 07-03-148 on January 23, 2007.

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

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

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

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

Date Adopted: February 28, 2007.

Jim Schnellman, Chief
Office of Administrative Resources

AMENDATORY SECTION (Amending WSR 06-16-073, filed 7/28/06, effective 8/28/06)

WAC 388-14A-3200 How does DCS determine my support obligation? (1) The division of child support (DCS) determines support obligations using the Washington state child support schedule (the WSCSS), which is found in chapter 26.19 RCW, for the establishment and modification of support orders.

(2) See WAC 388-14A-8100 for rules on completing the worksheets under the WSCSS for cases where DCS is determining support for a child in foster care.

(3) DCS does not have statutory authority to set the child support obligations of both the noncustodial parent (NCP) and custodial parent (CP) in the same administrative proceeding.

(a) DCS orders can not set off the support obligation of one parent against the other.

(b) Therefore, the method set forth in Marriage of Arvey, 77 Wn. App 817, 894 P.2d 1346 (1995), must not be applied when DCS determines a support obligation.

(4) The limitations in this section apply to DCS staff and to administrative law judges (ALJs) who are setting child support obligations.

AMENDATORY SECTION (Amending WSR 06-09-015, filed 4/10/06, effective 5/11/06)

WAC 388-14A-6300 Duty of the administrative law judge in a hearing to determine the amount of a support obligation. (1) A support order entered under this chapter must conform to the requirements set forth in RCW 26.23.050(3) and 26.23.050(5). The administrative law judge (ALJ) must comply with the DSHS rules on child support and include a Washington state child support schedule worksheet when entering a support order.

(2) In hearings held under this chapter to contest a notice and finding of financial responsibility or a notice and finding of parental responsibility or other notice or petition, the ((~~administrative law judge (ALJ)~~)) ALJ must determine:

(a) The noncustodial parent's obligation to provide support under RCW 74.20A.057;

(b) The names and dates of birth of the children covered by the support order;

(c) The net monthly income of the noncustodial parent (NCP) and any custodial parent (CP);

(d) The NCP's share of the basic support obligation and any adjustments to that share, according to his or her circumstances;

(e) If requested by a party, the NCP's share of any special child-rearing expenses in a sum certain amount per month;

(f) The NCP's obligation to provide medical support under RCW 26.18.170;

(g) The NCP's accrued debt and order payments toward the debt in a monthly amount to be determined by the division of child support (DCS);

(h) The NCP's current and future monthly support obligation as a per month per child amount and order payments in that amount; and

(i) The NCP's total current and future support obligation as a sum certain and order payments in that amount.

(3) Having made the determinations required in subsection (2) above, the ALJ must order the NCP to make payments to the Washington state support registry (WSSR).

(4) The ALJ must allow DCS to orally amend the notice at the hearing to conform to the evidence. The ALJ may grant a continuance, when necessary, to allow the NCP or the CP additional time to present rebutting evidence or argument as to the amendment.

(5) The ALJ may not require DCS to produce or obtain information, documents, or witnesses to assist the NCP or CP in proof of defenses to liability. However, this rule does not apply to relevant, nonconfidential information or documents that DCS has in its possession.

WSR 07-06-055
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed March 5, 2007, 8:54 a.m., effective April 5, 2007]

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

Purpose: The purpose of these amendments is to clarify a client's right to an administrative hearing and to move the language in WAC 388-827-0140(2) to WAC 388-825-150.

Citation of Existing Rules Affected by this Order: Amending WAC 388-825-150 and 388-827-0140.

Statutory Authority for Adoption: RCW 71A.12.030.

Other Authority: Title 71A RCW.

Adopted under notice filed as WSR 07-03-062 on January 16, 2007.

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

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

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

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

Date Adopted: March 2, 2007.

Jim Schnellman, Chief
Office of Administrative Resources

AMENDATORY SECTION (Amending WSR 05-17-135, filed 8/19/05, effective 9/19/05)

WAC 388-825-150 When can the department proceed to take action during my appeal? The department will proceed to take action during your appeal if:

(1) It is an eligibility denial and you are not currently an eligible client.

(2) Your DDD eligibility has expired, per WAC 388-823-0010 and 388-823-1040.

(3) There is no longer funding for state-only funded service.

(4) Your current services are terminated or transferred in order to meet the legislative intent of and comply with sections 205 and 207, chapter 371, Laws of 2002.

(5) The state-only funded service no longer exists, the Medicaid state plan has been amended, or the HCBS waiver agreement with the federal Centers for Medicare and Medicaid has been amended.

((~~(5)~~)) (6) The administrative law judge or review judge rules that you have caused unreasonable delay in the proceedings.

((~~(6)~~)) (7) You are in imminent jeopardy.

((~~(7)~~)) (8) Your provider is no longer qualified to provide services due to:

(a) A lack of a contract;

(b) Decertification;

(c) Revocation or suspension of a license; or

(d) Lack of required registration, certification, or licensure.

((~~(8)~~)) (9) The parent of a person under the age of eighteen or the legal guardian approves the department's decision.

((~~(9)~~)) (10) You did not file your request for an administrative hearing within the ten-day notice period, as described in chapter 388-458 WAC.

((~~(10)~~)) (11) You:

(a) Tell us in writing that you do not want continued benefits;

(b) Withdraw your administrative hearing request in writing; or

(c) Do not follow through with the administrative hearing process.

AMENDATORY SECTION (Amending WSR 04-02-015, filed 12/29/03, effective 1/29/04)

WAC 388-827-0140 What are my appeal rights if DDD determines that I am not eligible for DDD/SSP? ((~~(1)~~)) You have the right to appeal the department's denial, termination, or reduction of ((~~services~~)) your SSP. Your rights to an ((~~adjudicative proceeding~~)) administrative hearing are contained in WAC 388-825-120 through WAC 388-825-165.

((~~(2) Your current services will not be continued while the matter is being appealed if the service termination or transfer is for a specific group of clients in order to meet the legislative intent of and comply with sections 205 and 207, chapter 371, Laws of 2002.~~))

WSR 07-06-064
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed March 5, 2007, 1:49 p.m., effective April 5, 2007]

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

Purpose: The purpose of the proposed changes to chapter 392-185 WAC is to make appropriate agency name changes to be consistent with chapter 28A.205 RCW.

Citation of Existing Rules Affected by this Order: Amending chapter 392-185 WAC.

Statutory Authority for Adoption: Chapter 28A.205 RCW.

Adopted under notice filed as WSR 06-17-103 on August 16, 2006.

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

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

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

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

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

Date Adopted: March 5, 2007.

Dr. Terry Bergeson
Superintendent of
Public Instruction

AMENDATORY SECTION (Amending WSR 06-14-009, filed 6/22/06, effective 6/22/06)

WAC 392-185-310 Definitions. The following definitions shall apply to terms used in this chapter:

(1) "Education center" shall mean a private educational institution certified by the ((~~state board of education~~)) superintendent of public instruction which employs a clinical, client-centered approach and is devoted to (a) teaching the basic academic skills including specific attention to improvement of student motivation for achieving and (b) employment orientation: Provided, That no education center certified by the ((~~state board of education~~)) superintendent of public instruction pursuant to this section shall be deemed a common school under RCW 28A.150.020 or a private school for the purposes of RCW 28A.195.010 through 28A.195.050((~~, or proprietary school under chapter 18.82 RCW~~)).

(2) "Basic academic skills" shall mean the study of mathematics, speech, language, reading and composition, science, history, literature and political science or civics; it shall not include courses of a vocational training nature and courses deemed nonessential to the accrediting ((~~of common schools~~)) or the approval of private schools under RCW 28A.305.130.

(3) "A clinical, client-centered basis" shall mean an approach to education which includes the individual diagnosis of the person's educational abilities, determining and setting of individual goals, prescribing and providing individual programs of instruction, and evaluating the individual student's progress in his or her educational program.

(4) "Individual diagnostic procedure" shall mean the individual assessment by a certified teacher, or when deemed necessary, by a psychometrist, psychologist, and/or another professional who is appropriately certificated or licensed to conduct specific diagnostic evaluations and to prescribe an individual educational and instructional program in conjunction with the teacher, student, parents, and others as necessary.

(5) "General educational development (GED) tests" shall mean that battery of tests designed and published by the GED testing service of the American council on education to measure the major outcomes and concepts generally associated with four years of high school education. Each GED testing center must have a current contract with the American council on education and be authorized by the state ((~~superintendent of public instruction~~)) board for community and technical colleges.

(6) "Educational gain" shall mean (a) measurable increases in the student's achievement, (b) increased motivation for achieving, and/or (c) increased knowledge and skills relevant to employment orientation as defined in (8) below: Provided, That consideration is given to the student's background in determining the extent of such gain.

(7) "Eligible common school dropout" shall be defined as set forth in WAC 392-185-010(2).

(8) "Employment orientation" shall normally include, but not be restricted to instruction and practical experience in the following areas: Job applications, interview techniques, expectations for attendance and production, learning to translate skills and abilities in terms of job needs, examination by the student of job descriptions and exploration of the student's ability to fulfill the job needs.

AMENDATORY SECTION (Amending WSR 06-14-009, filed 6/22/06, effective 6/22/06)

WAC 392-185-320 Criteria for certification of education centers. To be certified as an education center, a private educational institution must apply to the ((~~state board of education~~)) superintendent of public instruction and provide evidence that it:

(1) Qualifies under the definition set forth in WAC 180-95-010(1).

(2) Offers instruction in the basic academic skills as defined in WAC 180-95-010(2) and employment orientation as defined in WAC 180-95-010(8).

(3) Employs, for purposes of diagnosing and instructing students, professionally trained personnel who meet requirements for certification set forth in chapters 180-80 and/or 180-84 WAC: Provided, That for specific diagnostic evaluations, a professional who is otherwise appropriately licensed does not have to meet certification requirements.

(4) Operates on a clinical, client-centered basis as defined in WAC 180-95-010(3).

(5) Conducts individualized diagnosis and instruction which includes as a minimum:

(a) Consideration by qualified personnel of the student's achievement, abilities, interests, and aptitudes;

(b) Delineation of individual learning objectives and education and/or employment goals;

(c) Development and implementation of curriculum and instruction appropriate to diagnosed needs and specified objectives and goals;

(d) Provision for evaluation of the student's progress toward and attainment of learning objectives and education and/or employment goals.

(6) Produces educational gains in students which relate directly to the individual learning objectives and educational and/or employment goals established for the student.

(7) Maintains accurate and complete financial and personnel records.

(8) Is financially sound and capable of fulfilling its educational commitment, i.e., that it has definite and certain resources to meet its current obligations.

AMENDATORY SECTION (Amending WSR 06-14-009, filed 6/22/06, effective 6/22/06)

WAC 392-185-330 Application procedures for certification as an education center. A private educational institution shall apply for certification to the ((~~state board of education~~)) superintendent of public instruction on a form provided by the ((~~state board of education~~)) superintendent of public instruction. The ((~~state board of education~~)) superintendent of public instruction or its designee(s) shall determine by ((~~on-site visitation and~~)) documentary evidence submitted by the applicant whether all criteria set forth in WAC 180-95-020 are satisfied. The ((~~state board of education~~)) superintendent of public instruction shall notify the applicant institution of its certification status within ten weeks after the

date ((~~state board of education~~)) the superintendent of public instruction receives a completed application.

AMENDATORY SECTION (Amending WSR 06-14-009, filed 6/22/06, effective 6/22/06)

WAC 392-185-340 Length of certification. A private educational institution shall be certified as an education center by the ((~~state board of education~~)) superintendent of public instruction for no more than three years and shall report annually any changes relevant to certification criteria set forth in WAC 180-95-020 to the ((~~state board of education~~)) superintendent of public instruction on a form provided by the ((~~state board of education~~)) superintendent of public instruction.

AMENDATORY SECTION (Amending WSR 06-14-009, filed 6/22/06, effective 6/22/06)

WAC 392-185-350 Withdrawal of certification as an education center. The ((~~state board of education~~)) superintendent of public instruction may withdraw certification if the board finds that a center fails:

(1) To provide adequate instruction in basic academic skills which shall mean:

(a) The center does not offer or make provision for instruction in all the basic skills defined in WAC 180-95-010(2), or

(b) Evidence/data do not verify educational gains which relate directly to the individual learning objectives and the educational and/or employment goals established, or

(c) The center does not provide opportunities for employment orientation.

(2) To meet any of the criteria for certification of education centers as established in WAC 180-95-020.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 392-185-360	Fee revision—Appeal procedure.
WAC 392-185-370	Additional rules.

WSR 07-06-066
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed March 5, 2007, 2:44 p.m., effective April 5, 2007]

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

Purpose: The department is amending WAC 388-478-0015 Need standards for cash assistance, in order to revise basic need standards for cash assistance.

Citation of Existing Rules Affected by this Order: Amending WAC 388-478-0015.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090.

Adopted under notice filed as WSR 07-03-149 on January 23, 2007.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 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: March 5, 2007.

Jim Schnellman, Chief
Office of Administrative Resources

AMENDATORY SECTION (Amending WSR 06-05-102, filed 2/14/06, effective 3/17/06)

WAC 388-478-0015 Need standards for cash assistance. The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard
1	$ ((~~989~~)) 1,016
2	((~~1,251~~)) 1,285
3	((~~1,545~~)) 1,587
4	((~~1,823~~)) 1,873
5	((~~2,101~~)) 2,158
6	((~~2,379~~)) 2,444
7	((~~2,749~~)) 2,825
8	((~~3,043~~)) 3,126
9	((~~3,336~~)) 3,428
10 or more	((~~3,630~~)) 3,729

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	$ ((~~528~~)) 546
2	((~~668~~)) 691
3	((~~825~~)) 853
4	((~~973~~)) 1,007
5	((~~1,122~~)) 1,161
6	((~~1,270~~)) 1,314
7	((~~1,468~~)) 1,519
8	((~~1,625~~)) 1,681
9	((~~1,782~~)) 1,843

Assistance Unit Size	Need Standard
10 or more	((~~1,939~~)) 2,005

WSR 07-06-077
PERMANENT RULES
DEPARTMENT OF REVENUE
[Filed March 6, 2007, 10:59 a.m., effective April 6, 2007]

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

Purpose: WAC 458-20-228 (Rule 228) discusses the responsibility of taxpayers to timely pay their tax liabilities, and the acceptable methods of payment. The rule explains the statutory due dates for persons remitting excise tax returns, and the interest and penalties imposed by law when a taxpayer fails to timely pay the correct amount of tax, as well as other penalties which may be applied. It provides examples of circumstances that qualify for a waiver of interest or penalties, and explains how a taxpayer may request a waiver of the same.

The rule was amended to recognize provisions of chapter 256, Laws of 2006 (HB 2671). This legislation extended the due date for persons filing excise tax returns on a monthly basis and modified the penalty provisions of RCW 82.32.-090(2).

The rule recognizes that the due date for persons filing excise tax returns on a monthly basis was extended to twenty-five days after the end of the month in which taxable activities occur. The due date previously was twenty days.

RCW 82.32.090(2) previously imposed a 5% penalty "whenever the department determined that any additional tax was due," with a total penalty of 15% being due if payment was not received by the assessment due date, and further a total penalty of 25% due if payment was not received by the thirtieth day following the assessment due date. The proposed rule recognizes that this legislation provides that the initial 5% penalty applies only if any tax has been "substantially underpaid," the statutory definition of which is incorporated into the rule. This legislation made no change to the imposition of the 15% and 25% penalties prescribed by RCW 82.32.090(2).

Additionally, the rule explains that RCW 82.32.105(2) provides a limited penalty waiver for a taxpayer that has timely filed and paid all tax returns due for a specific tax program for a period of twenty-four months immediately preceding the return for which the waiver is being requested. The rule currently explains that if a taxpayer has engaged in business activities for a period less than twenty-four months, the taxpayer may still be eligible for the waiver. The amended rule clarifies that even the first tax return is potentially eligible for the waiver.

Citation of Existing Rules Affected by this Order: Amending WAC 458-20-228 Returns, payments, penalties, extensions, interest, stay of collection.

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

Adopted under notice filed as WSR 07-01-119 on December 20, 2006.

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

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

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

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

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

Date Adopted: March 6, 2007.

Janis P. Bianchi
Assistant Director
Interpretations and
Technical Advice Division

AMENDATORY SECTION (Amending WSR 05-22-095, filed 11/1/05, effective 12/2/05)

WAC 458-20-228 Returns, payments, penalties, extensions, interest, stay of collection. (1) **Introduction.** This section discusses the responsibility of taxpayers to pay their tax by the appropriate due date, and the acceptable methods of payment. It discusses the interest and penalties that are imposed by law when a taxpayer fails to pay the correct amount of tax by the due date. It also discusses the circumstances under which the law allows the department of revenue (department) to waive interest or penalties.

(a) **Where can I get my questions answered, or learn more about what I owe and how to report it?** Washington's tax system is based largely on voluntary compliance. Taxpayers have a legal responsibility to become informed about applicable tax laws, to register with the department, to seek instruction from the department, to file accurate returns, and to pay their tax liability in a timely manner (chapter 82.32A RCW, Taxpayer rights and responsibilities). The department has a taxpayer services program to provide taxpayers with accurate tax-reporting assistance and instructions. The department staffs local district offices, maintains a toll-free question and information phone line (1-800-647-7706), provides information and forms on the internet (http://dor.wa.gov), and conducts free public workshops on tax reporting. The department also publishes notices, interpretive statements, and sections discussing important tax issues and changes. It's all friendly, free, and easy to access.

(b) ((~~**I can avoid some penalties and interest if I file my returns electronically (by e-file)?** It's true!~~)) **What is electronic filing (or e-file), and how can it help me?** Many common reporting errors are preventable when taxpayers take advantage of the department's electronic filing (e-file) system. E-file is an internet-based application that provides a secure and encrypted way for taxpayers to file and pay many of Washington state's business related excise taxes online. The e-file system helps taxpayers by performing all the math

calculations and checking for other types of reporting errors. **Using e-file to file electronically will help taxpayers avoid penalties and interest related to unintentional underpayments and delinquencies.** Persons who wish to use e-file should access the department's internet site (http://dor.wa.gov) and open the page for electronic filing, which has additional links to pages answering frequently asked questions, and explaining the registration process for e-file. Taxpayers may also call the department's toll-free electronic filing help desk for more information, during regular business hours.

(c) **Index of subjects addressed in this section:**

Topic—Description	**See subsection**
Where can I get my questions answered, or learn more about what I owe and how to report it? - By phone or on-line, the department provides a number of free and easy resources to help you find answers. One of them is right for you.	(1)(a) of this section, (see above)
((~~**I can avoid some penalties and interest if I file my returns electronically (by e-file)? -** It's true!~~)) **What is electronic filing (or e-file), and how can it help me? -** E-filing guides you through the return and helps you avoid many common mistakes.	(1)(b) of this section, (see above)
Do I need to file a return? - How do I get returns and file them? Can I file my returns electronically?	(2) of this section
What methods of payment can I use? - What can I use to pay my taxes? Some taxpayers are required to pay electronically.	(3) of this section
When is my tax payment due? - Different reporting frequencies can have different due dates. What if the due date is a weekend or a holiday? If my payment is in the mail on the due date, am I late or on time?	(4) of this section
Penalties - What types of penalty exist? How big are they? When do they apply?	(5) of this section
Statutory restrictions on imposing penalties - More than one penalty can apply at the same time, but there are restrictions. Which penalties can be combined?	(6) of this section
Interest - In most cases interest is required. What interest rates apply? How is interest applied?	(7) of this section
Application of payment towards liability - Interest, penalties, and taxes are paid in a particular order. If my payment doesn't pay the entire liability, how can I determine what parts have been paid?	(8) of this section
Waiver or cancellation of penalties - I think I was on time, or I had a good reason for not paying the tax when I should have. What reasons qualify me for a waiver of penalty? How can I get a penalty removed?	(9) of this section
Waiver or cancellation of interest - Interest will only be waived in two limited situations. What are they?	(10) of this section
Stay of collection - Revenue will sometimes temporarily delay collection action on unpaid taxes. When can this happen? Can I request that revenue delay collection?	(11) of this section
Extensions - Can I get an extension of my due date? How long does an extension last?	(12) of this section

(2) **Do I need to file a return?** A "return" is defined as any paper or electronic document a person is required to file by the state of Washington in order to satisfy or establish a tax or fee obligation which is administered or collected by the department, and that has a statutorily defined due date. RCW 82.32.090(8).

(a) Returns and payments are to be filed with the department by every person liable for any tax which the department administers and/or collects, except for the taxes imposed under chapter 82.24 RCW (Tax on cigarettes), which are collected through sales of revenue stamps. Returns must be made upon forms, through the electronic filing (e-file) system (see subsection (1)(b) of this section), or by other means, provided or accepted by the department. The department provides tax returns upon request or when a taxpayer opens an active tax reporting account. Tax returns are generally mailed to all registered taxpayers prior to the due date of the tax. However, it remains the responsibility of taxpayers to timely request a return if one is not received, or to otherwise insure that their return is filed in a timely manner. E-file taxpayers do not receive paper returns. However, if an e-file taxpayer specifically requests it, the department will send an electronic reminder for each upcoming return as the time to file approaches.

(b) Taxpayers whose accounts are placed on an "active nonreporting" status do not automatically receive a tax return and must request a return, or register to file by e-file, if they no longer qualify for this reporting status. (See WAC 458-20-101, Tax registration, for an explanation of the active nonreporting status.)

(c) Some consumers may not be required to register with the department and obtain a tax registration endorsement. (Refer to WAC 458-20-101 for detailed information about tax registration and when it is required.) But even if they do not have to be registered, consumers may be required to pay use tax directly to the department if they have purchased items without paying Washington's sales tax. An unregistered consumer must report and pay their use tax liability directly to the department on a "Consumer Use Tax Return." Consumer use tax returns are available from the department at

any of the local district offices. A consumer may also call the department's toll free number 1-800-647-7706 to request a consumer use tax return by fax or mail. Finally, the consumer use tax return is available for download from the department's internet site at http://dor.wa.gov, along with a number of other returns and forms which are available there.

The interest and penalty provisions of this rule may apply if use tax is not paid on time. Unregistered consumers should refer to WAC 458-20-178 (Use tax) for an explanation of their tax reporting responsibilities.

(3) **What methods of payment can I use?** Payment may be made by cash, check, cashier's check, money order, and in certain cases by electronic funds transfers, or other electronic means approved by the department.

(a) Payment by cash should only be made at an office of the department to ensure that the payment is safely received and properly credited.

(b) Payment may be made by uncertified bank check, but if the check is not honored by the financial institution on which it is drawn, the taxpayer remains liable for the payment of the tax, as well as any applicable interest and penalties. RCW 82.32.080. The department may refuse to accept any check which, in its opinion, would not be honored by the financial institution on which that check is drawn. If the department refuses a check for this reason the taxpayer remains liable for the tax due, as well as any applicable interest and penalties.

(c) The law requires that certain taxpayers pay their taxes through electronic funds transfers. The department notifies taxpayers who are required to pay their taxes in this manner, and can explain how to set up the electronic funds transfer process. (See WAC 458-20-22802 on electronic funds transfers.)

(4) **When is my tax payment due?** RCW 82.32.045 provides that payment of the taxes due with the excise tax return must be made monthly and within ((~~twenty~~)) twenty-five days after the end of the month in which taxable activities occur, unless the department assigns the taxpayer a longer reporting frequency. Payment of taxes due with returns covering a longer reporting frequency are due on or before the last day of the month following the period covered by the return. (For example, payment of the tax liability for a first quarter tax return is due on April 30th.) WAC 458-20-22801 (Tax reporting frequency—Forms) explains the department's procedure for assigning a quarterly or annual reporting frequency.

(a) If the date for payment of the tax due on a tax return falls upon a Saturday, Sunday, or legal holiday, the filing shall be considered timely if performed on the next business day. RCW 1.12.070 and 1.16.050.

(b) The postmark date as shown by the post office cancellation mark stamped on the envelope will be considered conclusive evidence by the department in determining if a tax return or payment was timely filed or received. RCW 82.32.-080. It is the responsibility of the taxpayer to mail the tax return or payment sufficiently in advance of the due date to assure that the postmark date is timely.

Refer to WAC 458-20-22802 (Electronic funds transfer) for more information regarding the electronic funds transfer process, due dates, and requirements.

(c) If a taxpayer suspects that it will not be able to file and pay by the coming due date, it may be able to obtain an extension of the due date to temporarily avoid additional penalties. Refer to subsection (12) of this section for details on requesting an extension.

(5) **Penalties.** Various penalties may apply as a result of the failure to correctly or accurately compute the proper tax liability, or to timely pay the tax. Separate penalties may apply and be cumulative for the same tax. Interest may also apply if any tax has not been paid when it is due, as explained in subsection (7) of this section. (The department's electronic filing system (e-file) can help taxpayers avoid additional penalties and interest. See subsection (1)(b) of this section for more information.)

The penalty types and rates addressed in this subsection are:

Penalty Type—Description	**Penalty Rate**	**See subsection**
Late payment of a return - Five percent added when payment is not received by the due date, and increases if the tax due remains unpaid.	5/15/25%	(5)(a) of this section
Unregistered taxpayer - Five percent added against unpaid tax when revenue discovers a taxpayer who has taxable activity but is not registered.	5%	(5)(b) of this section
Assessment - Five percent added when a tax assessment is issued <u>if the tax was "substantially underpaid,"</u> and increases if the tax due remains unpaid.	5/15/25% <u>or 0/15/25%</u>	(5)(c) of this section
Issuance of a warrant - Ten percent added when a warrant is issued to collect unpaid tax, and does not require actual filing of a lien.	10%	(5)(d) of this section
Disregard of specific written instructions - Ten percent added when the department has provided specific, written reporting instructions and tax is underpaid because the instructions are not followed.	10%	(5)(e) of this section
Evasion - Fifty percent added when tax is underpaid and there is an intentional effort to hide that fact.	50%	(5)(f) of this section
Misuse of resale certificates - Fifty percent added against unpaid sales tax when a buyer uses a resale certificate but should not have.	50%	(5)(g) of this section

Penalty Type—Description	Penalty Rate	See subsection
Failure to remit sales tax to seller - Ten percent added against sales tax when the department proceeds directly against a buyer who fails to pay sales tax to the seller as part of a sales taxable retail purchase.	10%	(5)(h) of this section
Failure to obtain the contractor's unified business identifier (UBI) number - A flat two hundred fifty dollar maximum penalty (does not require any tax liability) when specified businesses hire certain contractors but do not obtain and keep the contractor's UBI number.	$250 max	(5)(i) of this section

(a) **Late payment of a return.** RCW 82.32.090(1) imposes a five percent penalty if the tax due on a taxpayer's return is not paid by the due date. A total penalty of fifteen percent ((~~penalty~~)) is imposed if the tax due is not paid on or before the last day of the month following the due date, and a total penalty of twenty-five percent ((~~penalty~~)) is imposed if the tax due is still not paid on or before the last day of the second month following the due date. The minimum penalty for late payment is five dollars.

Various sets of circumstances can affect how the late payment of a return penalty is applied. See (a)(i) through (iii) of this subsection for some of the most common circumstances.

(i) **Will I avoid the penalty if I file my return without the payment?** The department may refuse to accept any return which is not accompanied by payment of the tax shown to be due on the return. If the return is not accepted, the taxpayer is considered to have failed or refused to file the return. RCW 82.32.080. Failure to file the return can result in the issuance of an assessment for the actual, or an estimated, amount of unpaid tax. Any assessment issued ((~~will~~)) may include an assessment penalty ((~~starting at five percent, which will increase the longer tax remains unpaid~~)). (See RCW 82.32.100 and (c) of this subsection for details of when and how the assessment penalty applies.) If the tax return is accepted without payment and payment is not made by the due date, the late payment of return penalty will apply.

(ii) **What if my account is given an active nonreporting status, but I later have taxes I need to report and pay?** WAC 458-20-101 provides information about the active nonreporting status available for tax reporting accounts. In general, the active nonreporting status allows persons, under certain circumstances, to engage in business activities subject to the Revenue Act without filing excise tax returns. Persons placed on an active nonreporting status by the department are required to timely notify the department if their business activities no longer meet the conditions to be in active nonreporting status. One of the conditions is that the person is not required to collect or pay a tax the department is authorized to collect. The late payment of return penalty will be imposed if a person on active nonreporting status incurs a tax liability that is not paid by the due date for taxpayers that are on an annual reporting basis (i.e., the last day of January next succeeding the year in which the tax liability accrued).

(iii) **I didn't register my business with the department when I started it, and now I think I was supposed to be paying taxes! What should I do?** You should fill out and send in a Master Application to get your business registered. It is important for you to register before the department identifies you as an unregistered taxpayer and contacts you about your business activities. (WAC 458-20-101 provides information about registering your business.) Except as noted below, if a person engages in taxable activities while unregistered, but then registers prior to being contacted by the department, the registration is considered voluntary. When a person voluntarily registers, the late payment of return penalty does not apply to those specific tax-reporting periods representing the time during which the person was unregistered.

(A) However, even if the person has voluntarily registered as explained above, the late payment of return penalty will apply if the person:

(I) Collected retail sales tax from customers and failed to remit it to the department; or

(II) Engaged in evasion or misrepresentation with respect to reporting tax liabilities or other tax requirements; or

(III) Engaged in taxable business activities during a period of time in which the person's previously open tax reporting account had been closed.

(B) Even though other circumstances may warrant retention of the late payment of return penalty, if a person has voluntarily registered, the unregistered taxpayer penalty (see (b) of this subsection) will not be due.

(b) **Unregistered taxpayer.** RCW 82.32.090(4) imposes a five percent penalty on the tax due for any period of time where a person engages in a taxable activity and does not voluntarily register prior to being contacted by the department. "Voluntarily register" means to properly complete and submit a master application to any agency or entity participating in the unified business identifier (UBI) program for the purpose of obtaining a UBI number, all of which is done before any contact from the department. For example, if a person properly completes and submits a master application to the department of labor and industries for the purpose of obtaining a UBI number, and this is done prior to any contact from the department of revenue, the department considers that person to have voluntarily registered. A person has not voluntarily registered if a UBI number is obtained by any means other than submitting a properly completed master application. WAC 458-20-101 (Tax registration and tax reporting) provides additional information regarding the UBI program.

(c) **Assessment.** If the department issues an assessment for ((~~unpaid~~)) substantially underpaid tax, a five percent penalty will be added to the assessment when it is issued. If any tax included in the assessment is not paid by the due date, or

by any extended due date, the penalty will increase to a total of fifteen percent against the amount of tax that remains unpaid. If any tax included in the assessment is not paid within thirty days of the original or extended due date, the penalty will further increase to a total of twenty-five percent against the amount of tax that remains unpaid. The minimum for this penalty is five dollars. RCW 82.32.090(2).

(i) As used in this section, "substantially underpaid" means that:

(A) The taxpayer has paid less than eighty percent of the amount of tax determined by the department to be due for all of the types of taxes included in, and for the entire period of time covered by, the department's examination; and

(B) The amount of underpayment is at least one thousand dollars. If both of these conditions are true when an assessment is issued, it will include the initial five percent assessment penalty. If factual adjustments are made after issuance of an assessment, and those adjustments change whether a taxpayer paid less than eighty percent of the tax due, the department will reevaluate imposition of the original five percent penalty.

(ii) If the initial five percent assessment penalty is included with an assessment when it is issued((.)), the penalty is calculated against the total amount of tax that was not paid when originally due and payable (see RCW 82.32.045). Audit payments made prior to issuance of an assessment will be applied to the assessment after calculation of the initial five percent assessment penalty. At the discretion of the department, preexisting credits or amendments paid prior to an audit or unrelated to the scope of the assessment may be applied before the five percent assessment penalty is calculated, reducing the amount of the penalty. Additional assessment penalty (((~~(plus ten percent increments at thirty and sixty days from issuance)~~))) is assessed against the amount of tax that remains unpaid at that particular time, after payments are applied to the assessment.

(d) **Issuance of a warrant.** If the department issues a tax warrant for the collection of any fee, tax, increase, or penalty, an additional penalty will immediately be added in the amount of ten percent of the amount of the tax due, but not less than ten dollars. RCW 82.32.090(3). Refer to WAC 458-20-217 for additional information on the application of warrants and tax liens.

(e) **Disregard of specific written instructions.** If the department finds that all or any part of a deficiency resulted from the disregard of specific written instructions as to reporting of tax liabilities, an additional penalty of ten percent of the additional tax found due will be imposed because of the failure to follow the instructions. RCW 82.32.090(5).

(i) **What is "disregard of specific written instructions"?** A taxpayer is considered to have received specific written instructions when the department has informed the taxpayer in writing of its tax obligations and specifically advised the taxpayer that failure to act in accordance with those instructions may result in this penalty being imposed. The specific written instructions may be given as a part of a tax assessment, audit, determination, or closing agreement. The penalty applies when a taxpayer does not follow the specific written instructions, resulting in underpayment of the tax due. The penalty may be applied only against the taxpayer given the specific written instructions. However, the taxpayer will not be considered to have disregarded the instructions if the taxpayer has appealed the subject matter of the instructions and the department has not issued its final instructions or decision.

(ii) **What if I try to follow the written instructions, but I still don't get it quite right?** The penalty will not be applied if the taxpayer has made a good faith effort to comply with specific written instructions.

(f) **Evasion.** If the department finds that all or any part of the deficiency resulted from an intent to evade the tax due, a penalty of fifty percent of the additional tax found to be due will be added. RCW 82.32.090(6). The evasion penalty is imposed when a taxpayer knows a tax liability is due but attempts to escape detection or payment of the tax liability through deceit, fraud, or other intentional wrongdoing. An intent to evade does not exist where a deficiency is the result of an honest mistake, miscommunication, or the lack of knowledge regarding proper accounting methods. The department has the burden of showing the existence of an intent to evade a tax liability through clear, cogent and convincing evidence.

(i) **Evasion penalty only applies to the specific taxes that a taxpayer intended to evade.** To the extent that the evasion involved only specific taxes, the evasion penalty will be added only to those taxes. The evasion penalty will not be applied to those taxes which were inadvertently underpaid. For example, if the department finds that the taxpayer intentionally understated the purchase price of equipment in reporting use tax and also inadvertently failed to collect or remit the sales tax at the correct rate on retail sales of merchandise, the evasion penalty will be added only to the use tax deficiency and not the sales tax.

(ii) **What actions may establish an intent to evade?** The following is a nonexclusive list of actions that are generally considered to establish an intent to evade a tax liability. This list should only be used as a general guide. A determination of whether an intent to evade exists may be ascertained only after a review of all the facts and circumstances.

(A) The use of an out-of-state address by a Washington resident to register property to avoid a Washington excise or use tax, when at the time of registration the taxpayer does not reside at the out-of-state address on a more than temporary basis. Examples of such an address include, but are not limited to, the residence of a relative, mail forwarding or post office box location, motel, campground, or vacation property;

(B) The willful failure of a seller to remit retail sales taxes collected from customers to the department; and

(C) The alteration of a purchase invoice or misrepresentation of the price paid for property (e.g., a used vehicle) to reduce the amount of tax owing.

(g) **Misuse of resale certificates.** Any buyer who uses a resale certificate to purchase items or retail services without payment of sales tax, and who is not entitled to use the certificate for the purchase, will be assessed a penalty of fifty percent of the tax due. RCW 82.32.291. The penalty can apply even if there was no intent to evade the payment of the tax. For more information concerning this penalty or the proper

use of a resale certificate, refer to WAC 458-20-102 (Resale certificates).

(h) **Failure to remit sales tax to seller.** The department may assert an additional ten percent penalty against a buyer who has failed to pay the seller the retail sales tax on taxable purchases, if the department proceeds directly against the buyer for the payment of the tax. This penalty is in addition to any other penalties or interest prescribed by law. RCW 82.08.050.

(i) **Failure to obtain the contractor's unified business identifier (UBI) number.** If a person who is liable for any fee or tax imposed by chapters 82.04 through 82.27 RCW contracts with another person or entity for work subject to chapter 18.27 RCW (Registration of contractors) or chapter 19.28 RCW (Electricians and electrical installations), that person must obtain and preserve a record of the UBI number of the person or entity performing the work. A person failing to do so is subject to the public works contracting restrictions in RCW 39.06.010 (Contracts with unregistered or unlicensed contractors prohibited), and a penalty determined by the director, but not to exceed two hundred and fifty dollars. RCW 82.32.070(2).

(6) **Statutory restrictions on imposing penalties.** Depending on the circumstances, the law may impose more than one type of penalty on the same tax liability. However, those penalties are subject to the following restrictions:

(a) The penalties imposed for the late payment of a return, unregistered taxpayer, assessment, and issuance of a warrant (see subsection (5)(a) through (d) of this section) may be applied against the same tax concurrently, each unaffected by the others, up to their combined maximum rates. Application of one or any combination of these penalties does not prohibit or restrict full application of other penalties authorized by law, even when they are applied against the same tax. RCW 82.32.090(7).

(b) The department may impose either the evasion penalty (subsection (5)(f) of this section) or the penalty for disregarding specific written instructions (subsection (5)(e) of this section), but may not impose both penalties on the same tax. RCW 82.32.090(8). The department also will not impose the penalty for the misuse of a resale certificate (subsection (5)(g) of this section) in combination with either the evasion penalty or the penalty for disregarding specific written instructions on the same tax.

(7) **Interest.** The department is required by law to add interest to assessments for tax deficiencies and overpayments. RCW 82.32.050 and 82.32.060. Interest applies to taxes only. (Refer to WAC 458-20-229 for a discussion of interest as it relates to refunds and WAC 458-20-230 for a discussion of the statute of limitations as applied to interest.)

(a) For tax liabilities arising before January 1, 1992, interest will be added at the rate of nine percent per annum from the last day of the year in which the deficiency is incurred until the date of payment, or December 31, 1998, whichever comes first. Any interest accrued on these liabilities after December 31, 1998, will be added at the annual variable interest rates described below in (e) of this subsection. RCW 82.32.050.

(b) For tax liabilities arising after December 31, 1991, and before January 1, 1998, interest will be added at the annual variable interest rates described below in (e) of this subsection, from the last day of the year in which the deficiency is incurred until the date of payment.

(c) For interest imposed after December 31, 1998, interest will be added from the last day of the month following each calendar year included in a notice, or the last day of the month following the final month included in a notice if not the end of the calendar year, until the due date of the notice. However, for 1998 taxes only, interest may not begin to accrue any earlier than February 1, 1999, even if the last period included in the notice is not at the end of calendar year 1998. If payment in full is not made by the due date of the notice, additional interest will be due until the date of payment. The rate of interest continues at the annual variable interest rates described below in (e) of this subsection. RCW 82.32.050.

(d) **How is interest applied to an assessment that includes underpaid tax from multiple years?** The following is an example of how the interest provisions apply. Assume that a tax assessment is issued with a due date of June 30, 2000. The assessment includes periods from January 1, 1997, through September 30, 1999.

(i) For calendar year 1997 tax, interest begins January 1, 1998, (from the last day of the year). When the assessment is issued the interest is computed through June 30, 2000, (the due date of the assessment).

(ii) For calendar year 1998 tax, interest begins February 1, 1999, (from the last day of the month following the end of the calendar year). When the assessment is issued interest is computed through June 30, 2000, (the due date).

(iii) For the 1999 tax period ending with September 30, 1999, interest begins November 1, 1999, (from the last day of the month following the last month included in the assessment period). When the assessment is issued interest is computed through June 30, 2000, (the due date).

(iv) Interest will continue to accrue on any portion of the assessed taxes which remain unpaid after the due date, until the date those taxes are paid.

(e) **How is each year's interest rate determined?** The annual variable interest rate will be an average of the federal short-term rate as defined in 26 U.S.C. Sec. 1274(d) plus two percentage points. The rate for each new year will be computed by taking an arithmetical average to the nearest percentage point of the federal short-term rate, compounded annually. The average is calculated using the federal short-term rates from January, April, July of the calendar year immediately preceding the new year, and October of the previous preceding year, as published by the United States Secretary of the Treasury. The interest rate will be adjusted on the first day of January of each year.

(f) **How is the interest applied if an assessment includes some years that are underpaid and some that are overpaid?** If the assessment contains tax deficiencies in some years and overpayments in other years with the net difference being a tax deficiency, the interest rate for tax deficiencies will also be applied to the overpayments. (Refer to WAC 458-20-229 for interest on refunds.)

(8) **Application of payment towards liability.** The department will apply taxpayer payments first to interest,

next to penalties, and then to the tax, without regard to any direction of the taxpayer. RCW 82.32.080.

In applying a partial payment to a tax assessment, the payment will first be applied against the oldest tax liability. For purposes of RCW 82.32.145 (Termination, dissolution, or abandonment of corporate business—Personal liability of person in control of collected sales tax funds), it will be assumed that any payments applied to the tax liability will be first applied against any retail sales tax liability. For example, an audit assessment is issued covering a period of two years, which will be referred to as "YEAR 1" (the earlier year) and "YEAR 2" (the most recent year). The tax assessment includes total interest and penalties for YEAR 1 and YEAR 2 of five hundred dollars, retail sales tax of four hundred dollars for YEAR 1, six hundred dollars retail sales tax for YEAR 2, two thousand dollars of other taxes for YEAR 1, and seven thousand dollars of other taxes for YEAR 2. The order of application of any payments will be first against the five hundred dollars of total interest and penalties, second against the four hundred dollars retail sales tax in YEAR 1, third against the two thousand dollars of other taxes in YEAR 1, fourth against the six hundred dollars retail sales tax of YEAR 2, and finally against the seven thousand dollars of other taxes in YEAR 2.

(9) **Waiver or cancellation of penalties.** RCW 82.32.105 authorizes the department to waive or cancel penalties under limited circumstances.

(a) **Circumstances beyond the control of the taxpayer.** The department will waive or cancel the penalties imposed under chapter 82.32 RCW upon finding that the underpayment of the tax, or the failure to pay any tax by the due date, was the result of circumstances beyond the control of the taxpayer. It is possible that a taxpayer will qualify for a waiver of one type of penalty, without obtaining a waiver for all penalties associated with a particular tax liability. Circumstances determined to be beyond the control of the taxpayer when considering a waiver of one type of penalty are not necessarily pertinent when considering a waiver of a different penalty type. For example, circumstances that qualify for waiver of a late payment of return penalty do not necessarily also justify waiver of the assessment penalty or the penalty for misuse of a resale certificate. Refer to WAC 458-20-102 (Resale certificates) for examples of circumstances which are beyond the control of the taxpayer specifically regarding the penalty for misuse of resale certificates found in RCW 82.32.291.

(i) A request for a waiver or cancellation of penalties should contain all pertinent facts and be accompanied by such proof as may be available. The taxpayer bears the burden of establishing that the circumstances were beyond its control and directly caused the late payment. The request should be made in the form of a letter; however, verbal requests may be accepted and considered at the discretion of the department. Any petition for correction of assessment submitted to the department's appeals division for waiver of penalties must be made within the period for filing under RCW 82.32.160 (within thirty days after the issuance of the original notice of the amount owed or within the period covered by any extension of the due date granted by the department), and must be in writing, as explained in WAC 458-20-100 (Appeals, small claims and settlements). Refund requests must be made within the statutory limitation period.

(ii) The circumstances beyond the control of the taxpayer must actually cause the late payment. Circumstances beyond the control of the taxpayer are generally those which are immediate, unexpected, or in the nature of an emergency. Such circumstances result in the taxpayer not having reasonable time or opportunity to obtain an extension of the due date or otherwise timely file and pay. Circumstances beyond the control of the taxpayer include, but are not necessarily limited to, the following.

(A) The return payment was mailed on time but inadvertently sent to another agency.

(B) Erroneous written information given to the taxpayer by a department officer or employee caused the delinquency. A penalty generally will not be waived when it is claimed that erroneous oral information was given by a department employee. The reason for not cancelling the penalty in cases of oral information is because of the uncertainty of the facts presented, the uncertainty of the instructions or information imparted by the department employee, and the uncertainty that the taxpayer fully understood the information given. Reliance by the taxpayer on incorrect advice received from the taxpayer's legal or accounting representative is not a basis for cancellation of a penalty.

(C) The delinquency was directly caused by death or serious illness of the taxpayer, or a member of the taxpayer's immediate family. The same circumstances apply to the taxpayer's accountant or other tax preparer, or their immediate family. This situation is not intended to have an indefinite application. A death or serious illness which denies a taxpayer reasonable time or opportunity to obtain an extension or to otherwise arrange timely filing and payment is a circumstance eligible for penalty waiver.

(D) The delinquency was caused by the unavoidable absence of the taxpayer or key employee, prior to the filing date. "Unavoidable absence of the taxpayer" does not include absences because of business trips, vacations, personnel turnover, or terminations.

(E) The delinquency was caused by the destruction by fire or other casualty of the taxpayer's place of business or business records.

(F) The delinquency was caused by an act of fraud, embezzlement, theft, or conversion on the part of the taxpayer's employee or other persons contracted with the taxpayer, which the taxpayer could not immediately detect or prevent, provided that reasonable safeguards or internal controls were in place. See (a)(iii)(E) of this subsection.

(G) The department does not respond to the taxpayer's request for a tax return (or other forms necessary to compute the tax) within a reasonable period of time, which directly causes delinquent filing and payment on the part of the taxpayer. This assumes that, given the same situation, if the department had provided the requested form(s) within a reasonable period of time, the taxpayer would have been able to meet its obligation for timely payment of the tax. In any case, the taxpayer has responsibility to insure that its return is filed in a timely manner (e.g., by keeping track of pending due dates) and must anticipatively request a return for that purpose, if one is not received. (Note: Tax returns and other forms are immediately available to download at no cost from the department's internet site, http://dor.wa.gov. When good

cause exists, taxpayers are advised to contact the department and request an extension of the due date for filing, before the due date of concern has passed. See subsection (12) of this section. Taxpayers who have registered to file electronically with e-file will avoid potential penalties relating to unreceived paper returns. See subsection (1)(b) of this section.)

(iii) The following are examples of circumstances that are generally not considered to be beyond the control of the taxpayer and will not qualify for a waiver or cancellation of penalty:

(A) Financial hardship;

(B) A misunderstanding or lack of knowledge of a tax liability;

(C) The failure of the taxpayer to receive a tax return form, EXCEPT where the taxpayer timely requested the form and it was still not furnished in reasonable time to mail the return and payment by the due date, as described in (a)(ii)(G) of this subsection;

(D) Registration of an account that is not considered a voluntary registration, as described in subsection (5)(a)(iii) and (b) of this section;

(E) Mistakes or misconduct on the part of employees or other persons contracted with the taxpayer (not including conduct covered in (a)(ii)(F) of this subsection); and

(F) Reliance upon unpublished, written information from the department that was issued to and specifically addresses the circumstances of some other taxpayer.

(b) **Waiver of the late payment of return penalty.** The late payment of return penalty (see subsection (5)(a) of this section) may be waived either as a result of circumstances beyond the control of the taxpayer (RCW 82.32.105(1) and (a) of this subsection) or after a twenty-four month review of the taxpayer's reporting history, as described below.

(i) If the late payment of return penalty is assessed on a return but is not the result of circumstances beyond the control of the taxpayer, the penalty will still be waived or canceled if the following two circumstances are satisfied:

(A) The taxpayer requests the penalty waiver for a tax return which was required to be filed under RCW 82.32.045 (taxes reported on the combined excise tax return), RCW 82.23B.020 (oil spill response tax), RCW 82.27.060 (tax on enhanced food fish), RCW 82.29A.050 (leasehold excise tax), RCW 84.33.086 (timber and forest lands), RCW 82.14B.030 (tax on telephone access line use); and

(B) The taxpayer has timely filed and paid all tax returns due for that specific tax program for a period of twenty-four months immediately preceding the period covered by the return for which the waiver is being requested. RCW 82.32.-105(2).

If a taxpayer has obtained a tax registration endorsement with the department prior to engaging in business within the state and has engaged in business activities for a period less than twenty-four months, the taxpayer is eligible for the waiver if the taxpayer had no delinquent tax returns for periods prior to the period covered by the return for which the waiver is being requested. As a result, the taxpayer's very first return due can qualify for a waiver under the twenty-four month review provision. (See also WAC 458-20-101 for more information regarding the tax registration and tax reporting requirements.) This is the only situation under which the department will consider a waiver when the taxpayer has not timely filed and paid tax returns covering an immediately preceding twenty-four month period.

(ii) A return will be considered timely for purpose of the waiver if there is no tax liability on it when it is filed. Also, a return will be considered timely if any late payment penalties assessed on it were waived or canceled due to circumstances beyond the control of the taxpayer (see (a) of this subsection). The number of times penalty has been waived due to circumstances beyond the control of the taxpayer does not influence whether the waiver in this subsection will be granted. A taxpayer may receive more than one of the waivers in this subsection within a twenty-four month period if returns for more than one of the listed tax programs are filed, but no more than one waiver can be applied to any one tax program in a twenty-four month period.

For example, a taxpayer files combined excise tax returns as required under RCW 82.32.045, and timber tax returns as required under RCW 84.33.086. This taxpayer may qualify for two waivers of the late payment of return penalty during the same twenty-four month period, one for each tax program. If this taxpayer had an unwaived late payment of return penalty for the combined excise tax return during the previous twenty-four month period, the taxpayer may still qualify for a penalty waiver for the timber tax program.

(iii) The twenty-four month period reviewed for this waiver is not affected by the due date of the return for which the penalty waiver is requested, even if that due date has been extended beyond the original due date.

For example, assume a taxpayer's September 2003 return has had the original due date of October ((~~20th~~)) twenty-fifth extended to November ((~~20th~~)) twenty-fifth. The return and payment are received after the November ((~~20th~~)) twenty-fifth extended due date. A penalty waiver is requested. Since the delinquent return represented the month of September 2003, the twenty-four months which will be reviewed begin on September 1, 2001, and end with August 31, 2003, (the twenty-four months prior to September 2003). All of the returns representing that period of time will be included in the review. The extension of the original due date has no effect on the twenty-four month period under review.

(iv) A twenty-four month review is only valid when considering waiver of the late payment of return penalty described in subsection (5)(a) of this section. The twenty-four month review process cannot be used as justification for a waiver of interest, assessment penalty, or any penalty other than the late payment of return penalty.

(10) **Waiver or cancellation of interest.** The department will waive or cancel interest imposed under chapter 82.32 RCW only in the following situations:

(a) The failure to pay the tax prior to issuance of the assessment was the direct result of written instructions given the taxpayer by the department; or

(b) The extension of the due date for payment of an assessment was not at the request of the taxpayer and was for the sole convenience of the department. RCW 82.32.105(3).

(11) **Stay of collection.** RCW 82.32.190 allows the department to initiate a stay of collection, without the request of the taxpayer and without requiring any bond, for certain tax liabilities when they may be affected by the outcome of a

question pending before the courts (see (a) of this subsection). RCW 82.32.200 provides conditions under which the department, at its discretion, may allow a taxpayer to file a bond in order to obtain a stay of collection on a tax assessment (see (b) of this subsection). The department will grant a taxpayer's stay of collection request, as described in RCW 82.32.200, only when the department determines that a stay is in the best interests of the state.

(a) Circumstances under which the department may consider initiating a stay of collection without requiring a bond (RCW 82.32.190) include, but are not necessarily limited to, the existence of the following:

(i) A constitutional issue to be litigated by the taxpayer, the resolution of which is uncertain;

(ii) A matter of first impression for which the department has little precedent in administrative practice; or

(iii) An issue affecting other similarly situated taxpayers for whom the department would be willing to stay collection of the tax.

(b) The department will give consideration to a request for a stay of collection of an assessment (RCW 82.32.200) if:

(i) A written request for the stay is made prior to the due date for payment of the assessment; and

(ii) Payment of any unprotested portion of the assessment and other taxes due is made timely; and

(iii) The request is accompanied by an offer of a cash bond, or a security bond that is guaranteed by a specified authorized surety insurer. The amount of the bond will generally be equal to the total amount of the assessment, including any penalties and interest. However, where appropriate, the department may require a bond in an increased amount not to exceed twice the amount for which the stay is requested.

(c) Claims of financial hardship or threat of litigation are not grounds that justify the granting of a stay of collection. However, the department will consider a claim of significant financial hardship as grounds for staying collection procedures, but this will be done only if a partial payment agreement is executed and kept in accordance with the department's procedures and with such security as the department deems necessary.

(d) If the department grants a stay of collection, the stay will be for a period of no longer than two calendar years from the date of acceptance of the taxpayer request, or thirty days following a decision not appealed from by a tribunal or court of competent jurisdiction upholding the validity of the tax assessed, whichever date occurs first. The department may extend the period of a stay originally granted, but only for good cause shown.

(e) Interest will continue to accrue against the unpaid tax portion of a liability under stay of collection. Effective January 1, 1997, the interest rates prescribed by RCW 82.32.190 and 82.32.200 changed from nine percent and twelve percent per annum, respectively, to the same predetermined annual variable rates as are described in subsection (7)(e) of this section.

(12) **Extensions.** The department, for good cause, may extend the due date for filing any return. Any permanent extension more than ten days beyond the due date, and any temporary extension in excess of thirty days, must be conditional upon deposit by the taxpayer with the department of an amount equal to the estimated tax liability for the reporting period or periods for which the extension is granted. This deposit is credited to the taxpayer's account and may be applied to the taxpayer's liability upon cancellation of the permanent extension or upon reporting of the tax liability where a temporary extension of more than thirty days has been granted.

The amount of the deposit is subject to departmental approval. The amount will be reviewed from time to time, and a change may be required at any time that the department concludes that such amount does not approximate the tax liability for the reporting period or periods for which the extension was granted.

WSR 07-06-086
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Filed March 7, 2007, 9:10 a.m., effective April 7, 2007]

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

Purpose: The amendments to WAC 232-12-017 Deleterious exotic wildlife, correct references to subsections that do not exist. WAC 232-12-017 (9)(b) and (11)(c) contain references to subsections "(1)(d)(iv) and (1)(d)(v)," but there are no such subsections. The correct subsections are "(1)(b)(iv) and (1)(b)(v)." The anticipated effect of correcting this typographical error is to make WAC 232-12-017 (9)(b) and (11)(c) enforceable.

Citation of Existing Rules Affected by this Order: Amending WAC 232-12-017 (Amending Order 02-223, filed 9/5/02, effective 10/6/02).

Statutory Authority for Adoption: RCW 77.12.047, 77.04.020, and 34.05.353.

Adopted under notice filed as WSR 07-02-103 on January 3, 2007.

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

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

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

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

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

Date Adopted: March 7, 2007.

J. P. Koenings
Director

AMENDATORY SECTION (Amending Order 02-223, filed 9/5/02, effective 10/6/02)

WAC 232-12-017 Deleterious exotic wildlife. (1) The following animals are hereby designated as deleterious exotic wildlife:

(a) Birds

In the family Anatidae, the mute swan (Cygnus olor)

(b) Mammals

(i) In the family Viverridae, the mongoose (all members of the genus Herpestes)

(ii) In the family Suidae, the wild boar (*Sus scrofa* and all wild hybrids)

(iii) In the family Tayassuidae, the collared peccary (javelina) (*Tayassu tajacu*)

(iv) In the family Bovidae, all members and hybrids of the following genera: Rupicapra (Chamois); Hemitragus (Tahr); Capra (goats, ibexes except domestic goat Capra (hircus); Ammotragus (Barbary sheep or Aoudad); Ovis (sheep), except domestic sheep Ovis aries; Damaliscus (Sassabies); Alcelaphus buselaphus (Hartebeest); Connochaetes (Wildebeests).

(v) In the family Cervidae, the European red deer (Cervus elaphus elaphus), all nonnative subspecies of Cervus elaphus, and all hybrids with North American elk; Fallow deer (Dama dama), Axis deer (Axix axis), Rusa deer or Sambar deer (Cervus unicolor, Cervus timorensis, Cervus mariannus and Cervus alfredi), Sika deer (Cervus Nippon), Reindeer (all members of the Genus Rangifer except Rangifer tarandus caribou), and Roedeer (all members of the Genus Capreolus).

(2) It is unlawful to import into the state, hold, possess, propagate, offer for sale, sell, transfer, or release live specimens of deleterious exotic wildlife, their gametes and/or embryo, except as provided under (3), (4), (5), (6), or (7) below and as provided in WAC 232-12-01701.

(3) Scientific research or display: The director may authorize, by written approval, a person to import into the state, hold, possess, and propagate live specimens of deleterious exotic wildlife for scientific research or for display by zoos or aquariums who are accredited institutional members of the American Association of Zoological Parks and Aquariums (AAZPA) provided:

(a) The specimens are confined to a secure facility,

(b) The specimens will not be transferred to any other location within the state, except to other AAZPA accredited facilities with written director approval or as otherwise authorized in writing by the director,

(c) The specimens will be euthanized and all parts incinerated at the end of the project, except federally listed endangered or threatened species may be retained or transferred where in compliance with federal law,

(d) The person will keep such records on the specimens and make such reports as the director may require, and

(e) The person complies with other requirements of this section.

(4) Retention or disposal of existing specimens lawfully in captivity:

(a) Specimens lawfully in captivity prior to January 18, 1991: A person holding exotic wildlife specimens in captivity which were classified by the wildlife commission as deleterious exotic wildlife on or before January 18, 1991 may retain the specimens of such deleterious exotic wildlife such person lawfully possessed prior to January 18, 1991 provided such person complies with subsections (4)(c) through (4)(h) hereunder and the other requirements of this section:

(b) Specimens lawfully in captivity prior to June 20, 1992: A person holding the following deleterious exotic wildlife specimens in captivity which were classified by the wildlife commission as deleterious exotic wildlife by operation of emergency rule filed June 19, 1992 (in the family Bovidae, Sassabies (all member of the Genus Damaliscus), Hartebeest (Alcelaphus buselaphus), Wildebeests (all members of the Genus Connochaetes), Markhor (Capra falconeri), and Marcopolo sheep (Ovis ammon); in the family Cervidae, Fallow deer (Dama dama), Axis deer (Axis axis), Sika deer (Cervus Nippon), Rusa deer or Sambar deer (Cervus unicolor, Cervus timorensis, Cervus mariannus and Cervus alfredi)), may retain the specimens of such deleterious exotic wildlife such person lawfully possessed prior to June 20, 1992, and the lawful progeny thereof provided such person complies with subsections (4)(c) through (4)(h) hereunder and the other requirements of this section and except as provided under subsection (7).

(c) The person reported to the director in writing the species, number and location of the specimens as required.

(d) The specimens are confined to a secure facility at the location reported,

(e) Live specimens are not propagated, except at AAZPA accredited facilities with the written permission of the director or as otherwise authorized in writing by the director,

(f) Live specimens shall be neutered, physically separated by sex, and/or rendered infertile by means of contraception, except at AAZPA accredited facilities with the written permission of the director,

(g) Live specimens are not released,

(h) Live specimens are not sold or transferred except:

(i) Live specimens in lawful possession may be permanently removed from the state of Washington or transported directly to slaughter where in accordance with other applicable law,

(ii) Federally listed endangered or threatened species may be transferred to AAZPA accredited facilities where in compliance with federal law,

(iii) Live specimens may be moved to the new primary residence of the possessor with the written approval of the director, provided all other requirements are satisfied and the total number of locations where animals are held is not increased.

(iv) AAZPA facilities may sell and/or transfer live specimens within the state with the written permission of the director.

(5) Retention or disposal of existing specimens lawfully in captivity prior to February 13, 1993: A person holding exotic wildlife specimens in captivity which are newly classified by the Wildlife Commission as deleterious exotic wildlife by operation of this rule (Reindeer (all members of the Genus Rangifer, except Rangifer tarandus caribou), and Roedeer (all members of the Genus Capreolus)), may retain the specimens of such deleterious exotic wildlife such person lawfully possessed prior to February 13, 1993, provided:

(a) The person reports to the director in writing by March 31, 1993, and reports annually thereafter, or as otherwise required by the director, the species, number, and location of such specimens,

(b) The person complies with subsections (4)(d) through (4)(h) herein and the other requirements of this section.

(6) The provisions of this section shall not prohibit the importation, possession, propagation, sale, transfer, or release of live specimens of federally listed threatened or endangered species, their gametes and/or embryo, where in compliance with federal law.

(7) Notwithstanding the provisions of subsection (2), Fallow deer (Dama dama) and reindeer (all members of the Genus Rangifer, except Rangifer tarandus caribou) may be imported into the state, held, possessed, propagated, offered for sale, sold, and/or transferred provided:

(a) The person complies with subsection (4)(c) through (4)(g) hereunder and the other requirements of this section, except for subsections (4)(e), (4)(f), and (4)(h), and

(b) The person complies with department of agriculture WAC 16-54-035 as now or hereafter amended except:

(i) Animals which have resided at any time east of a line drawn through the eastern boundaries of North Dakota, South Dakota, Nebraska, Kansas, Oklahoma, and the 100th Meridian where it passes through Texas or have had contact with or shared common ground with animals which have resided at any time east of such line shall not be imported into the state of Washington, unless specifically authorized in writing by the directors of the department of agriculture and the department of wildlife.

(c) No specimens affected with any infectious or communicable disease shall be imported into the state unless in compliance with all applicable laws and regulations and unless written permission is obtained from the directors of the department of agriculture and the department of wildlife.

(d) The specimens are confined to a secure facility.

(e) Reindeer may not be imported into, held, or possessed in Ferry, Stevens, or Pend Oreille counties or that portion of Spokane County north of Spokane River.

(8) Escaped animals

(a) Escaped deleterious exotic wildlife, including Fallow deer (Dama dama), and Reindeer (all members of the Genus Rangifer, except Rangifer tarandus caribou) will be considered a public nuisance. The department or any peace officer may seize, capture, or destroy deleterious exotic wildlife that have escaped the possessor's control. The former possessor shall be responsible for costs incurred by the department in recovering, maintaining, or disposing of such animals, as well as any damage to the state's wildlife or habitat.

(b) Escapes of deleterious exotic wildlife must be reported immediately to the department.

(c) The recapture or death of escaped deleterious exotic wildlife must be reported immediately to the department.

(9) Secure facility

(a) All deleterious exotic wildlife will be held in a secure facility. For the purpose of this rule, a secure facility is an enclosure so constructed as to prevent danger to the environment or wildlife of the state, including escape of deleterious exotic wildlife specimens or ingress of resident wildlife ungulates (hoofed animals). The adequacy of the facility shall be determined by the director or agents of the director.

(b) For deleterious exotic wildlife listed in subsections (1)((~~(d)~~)) (b)(iv) and (1)((~~(d)~~)) (b)(v), the "secure facility" must comply with the fencing requirements in subsection (10) unless otherwise authorized by the director in writing.

(10) Fencing requirements

(a) Perimeter fences must be, at a minimum, eight feet above ground level for their entire length. The bottom six feet must be mesh of sufficient size to prevent resident wildlife ungulates (hoofed animals) from entering and deleterious exotic wildlife from escaping. Supplemental wire required to attain a height of eight feet may be smooth, barbed, or woven wire (at least 12-1/2 gauge) with strands spaced not more than six inches apart.

(b) Perimeter fences constructed of high tensile wire must be supported by a post or stay at minimum intervals of eight feet.

(c) Perimeter fences must be at least 12-1/2 gauge woven wire, 14-1/2 gauge high-tensile woven wire, chain link, non-climbable woven fence, or other fence approved by the director.

(i) If the wire used is not a full eight feet in height, it must be overlapped one row and securely fastened at every other vertical row or woven together with cable.

(d) Electric fencing materials may be used on perimeter fences only as a supplement to conventional fencing materials.

(e) All gates in the perimeter fences must be self-closing, equipped with two locking devices, and installed only in locations that have been approved by the director. Double gates may be required at points in the perimeter fences subject to frequent vehicle traffic that is not related to activities involving the holding of deleterious exotic wildlife.

(f) Posts used in the perimeter fences must be:

(i) Wood (pressure treated), five-inch minimum diameter or an equivalent as approved by the director;

(ii) Spaced no more than twenty-four feet apart with stays or supports at eight foot intervals between the posts;

(iii) Extended at least eight feet above ground level;

(iv) Corners braced with wood or with an equivalent material as approved by the director.

(g) Fences must be maintained at all times to prevent deleterious exotic wildlife from escaping or resident wildlife ungulates (hoofed animals) from entering the enclosure. If such animals do pass through, under, or over the fence because of any topographic feature or other conditions, the person possessing deleterious exotic wildlife must immediately supplement the fence to prevent continued passage.

(h) For any fence existing prior to February 13, 1993, a person may petition the director in writing for a variance from the above fencing requirements. Any such petition must be filed no later than May 31, 1993 and must identify all aspects in which the existing fence does not meet the fencing requirements contained herein. On approval of the director, such person may maintain such existing fence with normal repair. However, any extension or relocation of existing fence must meet the fencing requirements contained herein.

(11) Marking requirements

(a) All live specimens of deleterious exotic wildlife except those listed in subsections (1)(a) and (1)(b), shall be permanently and individually identified by methods approved by the director,

(b) Identification assigned to an individual animal may not be transferred to any other animal.

(c) All specimens of deleterious exotic wildlife identified in subsections (1)(((~~(d)~~))) (b)(iv) and (1)(((~~(d)~~))) (b)(v) must be individually identified by the methods specified below.

(i) All live specimens of such deleterious exotic wildlife shall be marked with USDA Official ear tags or with ear tags supplied or approved by the department. Tags shall be applied in sequential order, and

(ii) All live specimens of such deleterious exotic wildlife shall be marked with a tattoo with an identifying number that has been recorded with the director. The tattoo must be placed on the left ear of the animal.

(d) All lawful progeny of deleterious exotic wildlife must be tagged and tattooed by December 31 of the year of birth or upon leaving the holding facility, whichever is earlier.

(e) Where allowed, if an animal is sold or transferred within the state, the tag and tattoo must accompany the animal. The new owner or possessor shall not renumber the animal.

(f) Where allowed, live specimens of deleterious exotic wildlife shall be marked prior to importation.

(g) No unmarked deleterious exotic wildlife may be sold or otherwise transferred from the holding facility.

(12) Testing of specimens

(a) Where allowed, prior to entry into the state of Washington, a person importing any member of the Genus Cervus which is identified in subsection (1)(v) herein must submit records of genetic tests, conducted by a professionally recognized laboratory to identify red deer genetic influence (genetic material from any member of any subspecies, race, or species of the elk-red deer-wapiti complex Cervus elaphus not indigenous to the state of Washington). Such testing shall be at the possessor's expense. Animals which are deemed by department of wildlife biologists upon examination to exhibit either: Behavioral (vocalization), morphological (size, rump patch, color) or biochemical indications of such influence (hemoglobin, superoxide dismutase, transferrin and post-transferrin, or others to be developed) may not be imported.

(b) The director may require a person currently possessing any member of the Genus Cervus which are identified in subsection (1)(v) herein to submit records of genetic tests, conducted by a professionally recognized laboratory to identify red deer genetic influence (genetic material from any member of any subspecies, race, or species of the elk-red deer-wapiti complex Cervus elaphus not indigenous to the state of Washington), for each individual cervid to the department. Such testing shall be at the possessor's expense. The director may require that any animal identified a red deer or having nonindigenous genetic influence be destroyed, removed from the state, or neutered.

(c) The director may require that all specimens of deleterious exotic wildlife lawfully in captivity be tested for brucellosis (brucella abortus), tuberculosis (mycobacterium bovis and mycobacterium tuberculosis), meningeal worm (Paralophostrongylus tenuis), and muscle worm (Elaphostrongylus cervis) in accordance with the procedures specified in department of agriculture WAC 16-54-035 as now or hereafter amended and/or for other disease or parasites determined to pose a risk to wildlife. The results of such tests shall be filed with the director as required.

(13) Reporting

(a) A person holding deleterious exotic wildlife in captivity shall submit a completed report no later than March 30, 1993 and then no later than January 31 of each year, or as otherwise required by the director, on a form provided by the department.

(b) Persons possessing deleterious exotic wildlife must notify the director within ten days of any change of such persons' address and/or location of the holding facility.

(14) Inspection

(a) All holding facilities for deleterious exotic wildlife located in the state are subject to inspection for compliance with the provisions of this section.

(b) Such inspections may take place without warrant or prior notice but shall be conducted at reasonable times and locations.

(15) Notification and disposition of diseased animals.

(a) Any person who has reason to believe that deleterious exotic wildlife being held pursuant to this rule have or have been exposed to a dangerous or communicable disease or parasite shall notify the department immediately.

(b) Upon having reason to believe that deleterious exotic wildlife held pursuant to this rule have been exposed to or contracted a dangerous or contagious disease or parasite, the director may order inspection of such animals by a licensed, accredited veterinarian or inspection agent. Inspection shall be at the expense of the possessor.

(c) The director shall determine when destruction of animals, quarantine, or disinfection is required at any facility holding deleterious exotic wildlife pursuant to this rule. If the director determines that destruction, quarantine, or disinfection is required, a written order shall be issued to the possessor describing the procedure to be followed and the time period for carrying out such actions. Such activities shall be at the expense of the possessor.

(16) Quarantine area

(a) Any facility holding deleterious exotic wildlife must have an approved quarantine facility within its exterior boundary or submit an action plan to the director that guarantees access to an approved quarantine facility within the state of Washington.

(i) An approved quarantine facility is one that meets criteria set by the Washington state department of agriculture.

(ii) The quarantine area must meet the tests of isolation, separate feed and water, escape security, and allowances for the humane holding and care of its occupants for extended periods of time.

(b) Should the imposition of a quarantine become necessary, the possessor must provide an on-site quarantine facility or make arrangements at such possessor's expense to transport the animals to the approved quarantine facility named in the quarantine action plan.

(17) Seizure

(a) The department of wildlife may seize any unlawfully possessed deleterious exotic wildlife.

(b) The cost of any seizure and/or holding of deleterious exotic wildlife may be charged to the possessor of such animals.