WSR 19-14-027
PROPOSED RULES
OFFICE OF FINANCIAL MANAGEMENT
[Filed June 25, 2019, 8:33 a.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.-330(1).

Title of Rule and Other Identifying Information: WAC 357-28-203 When must an employee receive premium pay? and 357-58-141 When must an employee receive premium pay?

Hearing Location(s): On August 8, 2019, at 8:30 a.m., at the Office of Financial Management (OFM), Raad Building, 5th Floor, Room 512, 128 10th Avenue S.W., Olympia, WA 98501.

Date of Intended Adoption: August 15, 2019.

Submit Written Comments to: Brandy Chinn, OFM, P.O. Box 47500, Olympia, WA 98501, email Brandy.Chinn @ofm.wa.gov, fax 360-586-4694, by August 1, 2019.

Assistance for Persons with Disabilities: Contact OFM, TTY 711 or 1-800-833-6384, by August 1, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: ESHB 1109 is the state operating budget for fiscal years 2019-2021. ESHB 1109 provides a premium pay for those employees who are assigned to work on McNeil Island at the Special Commitment Center, which is funded in section 207. Additionally ESHB 1109, section 950 provides that funding is provided in the operating budget for a five percent premium pay for employees working in King County. (ESHB 1109 is also referred to as chapter 415, Laws of 2019.)

Reasons Supporting Proposal: To align Title 357 WAC with the changes made in chapter 415, Laws of 2019.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.06.133.

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

Name of Proponent: [OFM], governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Brandy Chinn, 128 10th Avenue, Olympia, WA 98501, 360-407-4141.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Rules are related to internal government operations and are not subject to violation by a nongovernmental party. See RCW 34.05.328 (5)(b)(ii) for exemption.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

June 25, 2019
Roselyn Marcus
Assistant Director of
Legal and Legislative Affairs

NEW SECTION

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

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

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

(a) This subsection does not apply to employees at the University of Washington.

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

NEW SECTION

WAC 357-58-141 When must an employee receive premium pay? Premium pay at the rate specified in the compensation plan must be paid when an employee is:

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

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

(a) This subsection does not apply to employees at the University of Washington.

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

WSR 19-14-028
PROPOSED RULES
OFFICE OF FINANCIAL MANAGEMENT
[Filed June 25, 2019, 8:37 a.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.-330(1).

Title of Rule and Other Identifying Information: WAC 357-31-840 Who shall administer the foster parent shared leave pool?, 357-31-885 May employees donating leave for the purpose of the foster parent shared leave pool direct the donation to a specific individual?, and 357-31-920 When an employer and/or the department of children, youth, and families has determined that abuse of the foster parent shared leave pool has occurred will the employee be required to repay the shared leave drawn from the pool?

Hearing Location(s): On August 8, 2019, at 8:30 a.m., at the Office of Financial Management (OFM), Raad Building, 5th Floor, Room 512, 128 10th Avenue S.W., Olympia, WA 98501.

Date of Intended Adoption: August 15, 2019.

Submit Written Comments to: Brandy Chinn, OFM, P.O. Box 47500, Olympia, WA 98501, email Brandy.Chinn @ofm.wa.gov, fax 360-586-4694, by August 1, 2019.

Assistance for Persons with Disabilities: Contact OFM, TTY 711 or 1-800-833-6384, by August 1, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: SSB 5955 addresses various provisions for the department of children, youth, and families (DCYF) effective July 28, 2019. Section 6 of SSB 5955 amends RCW 41.04.674 which removes the requirement for OFM to adopt rules and policies governing the donation and use of shared leave from the foster parent shared leave pool (FPSLP) in consultation with the department of social and health services and requires OFM to adopt rules and policies governing the donation and use of shared leave from the FPSLP with DCYF.

Reasons Supporting Proposal: To align Title 357 WAC with the changes made to RCW 41.04.674 effective July 28, 2019.

Statutory Authority for Adoption: Chapter 41.06 RCW.

Statute Being Implemented: RCW 41.04.674.

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

Name of Proponent: [OFM], governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Brandy Chinn, 128 10th Avenue, Olympia, WA 98501, 360-407-4141.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Rules are related to internal government operations and are not subject to violation by a nongovernmental party. See RCW 34.05.328 (5)(b)(ii) for exemption.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

June 25, 2019
Roselyn Marcus
Assistant Director of
Legal and Legislative Affairs

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

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

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

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

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

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

WSR 19-14-029
PROPOSED RULES
OFFICE OF FINANCIAL MANAGEMENT
[Filed June 25, 2019, 8:40 a.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.-330(1).

Title of Rule and Other Identifying Information: WAC 357-26-035 What actions must an employer take to provide reasonable pregnancy accommodations?

Hearing Location(s): On August 8, 2019, at 8:30 a.m., at the Office of Financial Management (OFM), Raad Building, 5th Floor, Room 512, 128 10th Avenue S.W., Olympia, WA 98501.

Date of Intended Adoption: August 15, 2019.

Submit Written Comments to: Caroline Kirk, OFM, P.O. Box 47500, Olympia, WA 98501, email caroline.kirk@ofm.wa.gov, fax 360-586-4694, by August 1, 2019.

Assistance for Persons with Disabilities: Contact OFM, TTY 711 or 1-800-833-6384, by August 1, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Chapter 134, Laws of 2019 (SHB 1930) was passed during the 2019 legislative session with an effective date of July 28, 2019. This bill adds the requirement for employers to provide reasonable break time for an employee to express breast milk for two years after the child's birth each time the employee has need to express the milk and providing a private location, other than a bathroom, if such a location exists at the place of business or worksite, which may be used by the employee to express breast milk.

Reasons Supporting Proposal: To align Title 357 WAC with the changes made to RCW 43.10.005 effective July 28, 2019.

Statutory Authority for Adoption: Chapter 43.01 RCW.

Statute Being Implemented: RCW 43.10.005.

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

Name of Proponent: [OFM], governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Caroline Kirk, 128 10th Avenue, Olympia, WA 98501, 360-407-4136.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Rules are related to internal government operations and are not subject to violation by a nongovernmental party. See RCW 34.05.328 (5)(b)(ii) for exemption.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

June 25, 2019
Roselyn Marcus
Assistant Director of
Legal and Legislative Affairs

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

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

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

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

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

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

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

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

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

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

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

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

WSR 19-14-035
PROPOSED RULES
ENVIRONMENTAL AND LAND USE HEARINGS OFFICE
(Pollution Control Hearings Board)

[Filed June 25, 2019, 3:01 p.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.-330(1).

Title of Rule and Other Identifying Information: WAC 223-08-087 Commencing an appeal—Temporary suspension or discontinuance, this rule is a procedural rule which establishes the process for an appellant to request, and the board to consider, the temporary suspension or discontinuance (stay) of an approved forest practices application or a stop work order.

WAC 371-08-415 Stays, this rule is the general rule addressing the process for requesting a stay from the pollution control hearings board (PCHB).

Hearing Location(s): On August 20, 2019, at 2:00 p.m., at the Environmental and Land Use Hearings Office, 1111 Israel Road S.W., Suite 301, Tumwater, WA 98501.

Date of Intended Adoption: September 10, 2019, at 10:00 a.m.

Submit Written Comments to: Nancy Coverdell, P.O. Box 40903, Olympia, WA 98503, email nancy.coverdell@eluho.wa.gov, fax 360-586-2253, by August 16, 2019.

Assistance for Persons with Disabilities: Contact Nancy Coverdell, phone 360-664-9171, fax 360-586-2253, TTY 711, email nancy.coverdell@eluho.wa.gov, by August 13, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Jurisdiction over forest practices appeals was assigned to PCHB in 2010, when the forest practices appeals board (FPAB) was abolished. See section 19, chapter 210, Laws of 2010. At that time, both boards had rules addressing stays, although FPAB's rule called the process a "temporary suspension and discontinuance" instead of a stay. The rules are dissimilar in several ways.

The PCHB rule, WAC 371-08-415, sets out a standard for granting a stay based on RCW 43.21B.320. The FPAB rule, WAC 223-08-087, does not contain a standard except for emergency situations. WAC 223-08-087(4). When applying WAC 223-08-087, FPAB relied on case law for the standard for granting a preliminary injunction. See *Tyler Pipe Indus. v. Dept. of Revenue*, 96 Wn.2d 785, 638 P.2d 1213 (1982). The *Tyler Pipe* standard is different than the standard in RCW 43.21B.320.

Another significant difference between the two stay rules is that the PCHB rule does not require posting of security, while the FPAB rule does.

After abolition of FPAB, PCHB retained WAC 223-08-087 and applied it only to forest practices appeals. PCHB continued to apply WAC 371-08-415, to requests for stays in all matters except forest practices appeals.

The purpose of this rule making is threefold: (1) To clarify for parties appearing before PCHB on forest practices appeals that the general PCHB stay rule, WAC 371-08-415, does not apply to forest practices stays. Instead, the applicable rule is WAC 223-08-087. This has been PCHB's practice since it was assigned jurisdiction over forest practices appeals in 2010. See WSR 10-18-021; *Yockey v. DNR*, PCHB No. 15-031 (April 14, 2015). (2) To amend WAC 223-08-087 to conform to PCHB's current practice when handling requests for stays in forest practices appeals. (3) To clarify that a request for a "temporary suspension or discontinuance" means a request for a stay. This rule amendment is not intended to change current practice, but instead to provide better guidance regarding what current practice is.

Reasons Supporting Proposal: The board believes that clarifying which stay rule is applicable to forest practices, and what the board's current practices are for processing forest practices stay requests, is helpful to parties appearing before the board.

Statutory Authority for Adoption: RCW 43.21B.170, 43.21B.110 (1)(j), 34.05.422(4), 34.05.479.

Statute Being Implemented: RCW 43.21B.170.

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

Name of Proponent: Environmental and land use hearings office, PCHB, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Kay M. Brown, Board Chair, 1111 Israel Road S.W., Suite 301, Tumwater, 98501, 360-664-9174.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This rule is not covered by subsection (5) of RCW 34.05.328, and therefore no cost-benefit analysis is required. This rule is a procedural rule pursuant to RCW 34.05.328 (5)(c)(i)(A).

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules adopt, amend, or repeal a procedure, practice, or requirement relating to agency hearings; or a filing or related process requirement for applying to an agency for a license or permit.

June 25, 2019

Kay M. Brown, Board Chair

Pollution Control Hearings Board

AMENDATORY SECTION (Amending WSR 90-23-093, filed 11/21/90, effective 12/22/90)

WAC 223-08-087 Commencing an appeal—Temporary suspension or discontinuance (stay). Any county appealing under RCW 76.09.050(8) or any person aggrieved appealing under RCW ((~~76.09.220(8)~~)) 76.09.205 may seek a ((~~temporary suspension~~)) stay of the department's approval, in whole or in part, pending such appeal. Any operator, timber owner, or forest land owner appealing under RCW 76.09.080 may seek ((~~temporary discontinuance~~)) a stay of the stop work order, in whole or in part, pending such appeal. The following procedure shall apply:

(1) The appellant shall file with the appeals board a motion, supported by affidavit setting forth specific facts supporting a ((~~temporary suspension or discontinuance~~)) stay. Such motion may be filed with the notice commencing the appeal or at any time thereafter prior to the final decision of the appeal by the appeals board.

(2) Upon receipt of said motion, the presiding officer shall schedule a ((~~hearing~~)) conference and serve notice of ((~~such hearing~~)) the conference on all parties to the appeal. ((~~Before or after the commencement of said hearing the presiding officer may order the hearing of the merits to be consolidated with said hearing.~~)) At the conference, a briefing schedule will be established to address the motion. Before or after the commencement or completion of briefing the presiding officer may determine that an evidentiary hearing is required. The hearing of the merits of the appeal may be consolidated with said hearing.

(3) After ((~~hearing~~)) the briefing is completed, the appeals board or the presiding officer ((~~shall temporarily suspend~~)) may stay the department's approval((~~, or temporarily discontinue the~~)) or a stop work order, in whole or in part, or ((~~shall~~)) decline to ((~~suspend or discontinue~~)) stay. Such action shall be based solely on the record ((~~and hearing argument~~)), and shall be embodied in a written order. Orders issued under this subsection shall remain effective until the final decision of the appeals board unless sooner dissolved for good cause shown.

(4) In emergency situations, a ((~~temporary suspension or discontinuance~~)) stay in whole or in part may be granted by the presiding officer without a ((~~hearing~~)) conference and/or briefing, only if it clearly appears from specific facts shown by affidavit that immediate and irreparable injury, loss, or damage will result to the moving party before any adverse party can be heard in opposition. A ((~~temporary suspension or discontinuance~~)) stay granted without ((~~a hearing~~)) briefing shall be embodied in a written order and shall expire by its terms within such time after entry, not to exceed fourteen days, as provided therein unless within the time so fixed the order, for good cause shown, is extended for a like period or unless the party against whom the order is directed consents that it may be extended for a longer period. The reasons for the extension shall be entered of record. On two days' notice to the party who obtained the ((~~temporary suspension or discontinuance~~)) stay without notice or on such shorter notice to that party as the presiding officer may prescribe, the adverse party may appear and move its dissolution or modification and in that event the presiding officer or appeals board shall

proceed to ((~~hear~~)) review and determine such motion as expeditiously as the ends of justice require.

(5) Every order ((~~temporarily suspending~~)) staying the department's approval of an application((~~,~~)) or ((~~temporarily discontinuing~~)) a stop work order, whether issued before or after ((~~hearing~~)) briefing, shall set forth the reasons for its issuance and shall describe in reasonable detail the scope of ((~~suspension or discontinuance~~)) the stay and shall be filed at the principal office of the appeals board and shall be binding upon all parties to the appeal, their officers, agents, servants, employees, and attorneys and upon those persons in active concert of participation with them who receive actual notice of the order.

(6) Except as otherwise provided by statute, no ((~~temporary suspension or discontinuance~~)) stay shall issue except upon the giving of security by the moving party, in such sum as the presiding officer deems proper, for payment of such costs and damages as may be incurred or suffered by any party who is found to have wrongfully obtained the ((~~suspension or discontinuance~~)) stay. No such security shall be required of the United States or of an officer or agency thereof. Pursuant to RCW 4.92.080 no security shall be required of the state of Washington, municipal corporations, or political subdivisions of the state of Washington.

AMENDATORY SECTION (Amending WSR 96-15-003, filed 7/3/96, effective 8/3/96)

WAC 371-08-415 Stays. (1) A person appealing an order not stayed by the issuing agency, and not issued pursuant to chapter 76.09 RCW may obtain a stay of the effectiveness of that order only as set forth in this section.

(2) An appealing party may request a stay by including such a request in the notice of appeal or in a subsequent motion. The request must be accompanied by a statement of grounds for the stay and evidence setting forth the factual basis upon which the request is based.

(3) Upon receipt of a request for a stay, the board will confer with the parties regarding its disposition. If necessary, a hearing on the motion will be held. If it appears that a hearing on the merits and issues of the case should be consolidated with the request for a stay, the board will advance the hearing date on its own initiative or by request of the parties.

(4) The ((~~requester~~)) requestor makes a prima facie case for a stay if the ((~~requester~~)) requestor demonstrates either a likelihood of success on the merits of the appeal or irreparable harm. Upon such a showing, the board shall grant the stay unless the agency demonstrates either:

(a) A substantial probability of success on the merits; or

(b) Likelihood of success and an overriding public interest which justifies denial of the stay.

(5) Unless otherwise stipulated by the parties, the board, after granting or denying a request for a stay, shall expedite the hearing and decision on the merits.

(6) Any party aggrieved by the grant or denial of a stay by the board may petition the superior court of Thurston County for review of that decision pending the hearing on the merits before the board.

(7) A person appealing an order not stayed by the issuing agency and issued pursuant to chapter 76.09 RCW may obtain a stay of the effectiveness of that order pursuant to WAC 223-08-087.

WSR 19-14-038
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed June 26, 2019, 11:05 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-03-149.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-97-4425 Notice—Service complete, 388-97-4430 Notice—Proof of service, and 388-97-4440 Appeal rights.

Hearing Location(s): On August 6, 2019, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than August 7, 2019.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., August 6, 2019.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email kildaja@dshs.wa.gov, by July 23, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendments to these rules will clarify that notices can be delivered and proof of service can be obtained electronically through the federal web site, and will also clarify the nursing home's right to appeal WAC deficiency findings under the state appeal process, regardless of the delivery method of the deficiency report.

Reasons Supporting Proposal: These amendments will clarify rules to ensure providers can appeal state deficiencies delivered through the federal electronic web site. The amendments will also expand delivery methods and proof of service methods to include electronic delivery using the federal web site, improving the efficiency of communication between the department and the providers.

Statutory Authority for Adoption: RCW 74.42.620.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting: Lisa Herke, P.O. Box 45600, Olympia, WA 98504, 509-225-2819; Implementation: Candace Goehring, P.O. Box 45600, Olympia, WA 98504, 360-725-2401; and Enforcement: Bett Schlemmer, P.O. Box 45600, Olympia, WA 98504, 360-725-2404.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Under RCW 34.05.328 (5)(b)(iii), a cost-benefit analysis is not required for rules adopting or incorporating by reference without material change federal statutes or regulations or Washington state statutes.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal: Is exempt under RCW 19.85.030.

Explanation of exemptions: The department has analyzed the proposed rule and concluded that no new costs will be imposed on small businesses affected by them. The preparation of a comprehensive small business economic impact statement is not required under RCW 19.85.030.

June 24, 2019
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-02-021, filed 12/29/09, effective 1/29/10)

WAC 388-97-4425 Notice—Service complete. Service of the department notices is complete when:

(1) Personal service is made;

(2) The notice is addressed to the facility or to the individual at his or her last known address, and deposited in the United States mail;

(3) The notice is faxed and the department receives evidence of transmission;

(4) Notice is delivered to a commercial delivery service with charges prepaid; ((~~or~~))

(5) Notice is delivered to a legal messenger service with charges prepaid((~~.~~)); or

(6) Notice is sent electronically, including through the federal website.

AMENDATORY SECTION (Amending WSR 10-02-021, filed 12/29/09, effective 1/29/10)

WAC 388-97-4430 Notice—Proof of service. The department may establish proof of service by any of the following:

(1) A declaration of personal service;

(2) An affidavit or certificate of mailing to the nursing home or to the individual to whom the notice is directed;

(3) A signed receipt from the person who accepted the certified mail, the commercial delivery service, or the legal messenger service package; ((~~or~~))

(4) Proof of fax transmission((~~.~~)); or

(5) Proof of electronic transmission.

AMENDATORY SECTION (Amending WSR 10-02-021, filed 12/29/09, effective 1/29/10)

WAC 388-97-4440 Appeal rights. (1) The appeal rights in this section apply to any appealable action taken by the department under chapters 18.51, 74.42 and 74.39A RCW. Notice and appeal requirements for resident protection program findings are described in WAC 388-97-0720 and 388-97-0740.

(2) The following actions may be appealed:

(a) Imposition of a penalty under RCW 18.51.060 or 74.42.580;

(b) A denial of a license under RCW 18.51.054, a license suspension under RCW 18.51.067 or a condition on a license under RCW 74.39A.050; or

(c) Deficiencies cited on the state survey report and any other deficiencies cited under state law.

(3) The appeal process will be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 18.51.065 and 74.42.580, chapter 388-02 WAC and this chapter. If there is a conflict between chapter 388-02 WAC and this chapter, this chapter will govern.

(4) The purpose of an administrative hearing will be to review actions taken by the department under chapters 18.51, 74.42 or 74.39A RCW, and under this chapter.

(5) The office of administrative hearings must receive an administrative hearing request from the applicant, licensee, or nursing home within twenty days of receipt of written notification of the department's action listed in subsection (2) of this section. Further information about administrative hearings is available in chapter 388-02 WAC and at the office of administrative hearings (OAH) web site: www.oah.wa.gov.

(6) Orders of the department imposing a stop placement, license suspension, emergency closure, emergency transfer of residents, temporary management, or conditions on a license are effective immediately upon verbal or written notice and must remain in effect until they are rescinded by the department or through the state administrative appeals process.

(7) Federal deficiencies cited on the federal survey report may not be appealed through the state administrative appeals process. If a federal remedy is imposed, the Centers for Medicare and Medicaid Services will notify the nursing facility of appeal rights under the federal administrative appeals process.

WSR 19-14-061
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed June 28, 2019, 10:25 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-08-096.

Title of Rule and Other Identifying Information: WAC 182-552-0001 Respiratory care—General, 182-552-1400 Respiratory care—Reimbursement—General, and 182-552-1600 Respiratory care equipment and supplies—Reimbursement—Methodology for purchase, rental, and repair.

Hearing Location(s): On August 6, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Apple Conference Room 127, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than August 7, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by August 6, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by August 2, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is amending these rules to align with section 503 of the Consolidated Appropriations Act, 2016 and section 5002 of the 21st Century Cures Act of 2016, which added section 1903 (i)(27) to the Social Security Act.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; 42 C.F.R. 431.16, Section 1903 (i)(27) of the Social Security Act.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is necessary because of federal law, 42 C.F.R. 431.16, Section 1903 (i)(27) of the Social Security Act.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Crabbe, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9563; Implementation and Enforcement: Robin Brake, P.O. Box 45500, Olympia, WA 98504-5500, 360-725-0469.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation of the specific federal statute or regulation and description of the consequences to the state if the rule is not adopted: 42 C.F.R. 431.16, Section 1903 (i)(27) of the Social Security Act.

June 28, 2019
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-14-022, filed 6/25/12, effective 8/1/12)

WAC 182-552-0001 Respiratory care—General. (1) The respiratory care, equipment, and supplies described in this chapter ((~~is considered part of the agency's durable medical equipment (DME) benefit. This chapter~~)) applies to:

(a) Medicaid clients who require respiratory care in their homes, community residential settings, and skilled nursing facilities;

(b) Providers who supply respiratory care to medicaid clients; and

(c) Licensed health care professionals whose scope of practice allows for the provision of respiratory care.

(2) The ((~~medicaid~~)) agency covers the respiratory care listed in this chapter according to the limitations and requirements in this chapter.

(3) The ((~~medicaid~~)) agency pays for respiratory care for medicaid clients when it is:

(a) Covered;

(b) Within the scope of the eligible client's medical care program;

(c) Medically necessary, as defined under chapter 182-500 WAC;

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC) within the scope of his or her licensure;

(e) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid ((~~provider~~)) billing guides and provider ((~~notices~~)) alerts;

(f) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid ((~~provider~~)) billing guides and provider ((~~notices~~)) alerts; and

(g) Provided and used within accepted medical or respiratory care community standards of practice.

(4) The agency does not require prior authorization for requests for covered respiratory care for medicaid clients that meets the clinical criteria set forth in this chapter.

(5) The agency requires prior authorization for covered respiratory care for medicaid clients when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The ((~~medicaid~~)) agency evaluates requests requiring prior authorization on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-552-1300, 182-552-1325, 182-552-1350, and 182-552-1375 for specific details regarding authorization.

(6) The agency evaluates on a case-by-case basis for medical necessity and appropriateness items, procedures, and services that do not have an established procedure code available and which are billed using miscellaneous procedure codes.

AMENDATORY SECTION (Amending WSR 12-14-022, filed 6/25/12, effective 8/1/12)

WAC 182-552-1400 Respiratory care—Reimbursement—General. (1) The medicaid agency pays qualified providers who meet all of the conditions in WAC 182-502-0100, for covered respiratory care provided on a fee-for-service (FFS) basis as follows:

(a) To medicaid agency-enrolled ((~~durable~~)) medical equipment (((~~DME~~))) and supplies providers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the procedures and codes in the agency's current respiratory care medicaid ((~~provider~~)) billing guide; and

(b) In accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignment.

(2) ((~~The medicaid agency updates the maximum allowable fees for respiratory care at least once per year, unless otherwise directed by the legislature or unless deemed necessary by the agency.~~

~~(3) The medicaid agency sets, evaluates, and updates the maximum allowable fees for respiratory care using available published information including, but not limited to:~~

~~(a) Commercial databases;~~

~~(b) Manufacturer's catalogs;~~

~~(c) Medicare fee schedules; and~~

~~(d) Wholesale prices.~~

~~(4)~~)) The medicaid agency may adopt policies, procedure codes, ((~~and/or~~)) and rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary.

(((~~5~~))) (3) The medicaid agency's maximum payment for respiratory care is the lesser of either of the following:

(a) Provider's usual and customary charges; or

(b) Established rates, except as provided in WAC 182-502-0110(3).

(((~~6~~))) (4) The medicaid agency is the payer of last resort for clients with medicare or third-party insurance.

(((~~7~~))) (5) The medicaid agency does not pay for respiratory care provided to a client who is enrolled in an agency-contracted managed care organization (MCO), but who did not use one of the MCO's participating providers.

(((~~8~~))) (6) The medicaid agency's ((~~reimbursement~~)) payment rate for covered oxygen and respiratory equipment and supplies includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the date of delivery or are covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Any pick-up ((~~and/or~~)) and delivery fees or associated costs (e.g., mileage, travel time, gas, etc.);

(c) Telephone calls;

(d) Shipping, handling, ((~~and/or~~)) and postage;

(e) Maintenance for rented equipment including, but not limited to, testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting ((~~and/or~~)) or setup, or both; and

(g) Instruction to the client or client's caregiver in the appropriate use of the respiratory care.

(((~~9~~))) (7) Respiratory care equipment, supplies, and related repairs and labor charges that are supplied to eligible clients under the following ((~~reimbursement~~)) payment methodologies are included in those methodologies and are not reimbursed under fee-for-service (FFS):

(a) Hospice provider's per diem reimbursement;

(b) Hospital's diagnosis-related group (DRG) reimbursement;

(c) Managed care organization's capitation rate;

(d) Skilled nursing facilities per diem rate; and

(e) Professional service's resource-based relative value system reimbursement (RBRVS) rate.

(((~~10~~))) (8) The provider must make warranty information, including date of purchase, applicable serial number, model number or other unique identifier of the respiratory care equipment, and warranty period, available to the medicaid agency upon request.

(((~~11~~))) (9) The dispensing provider who furnishes respiratory care equipment or supplies to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any equipment or supply that the medicaid agency considers purchased requires repair during the applicable warranty period;

(b) The provider refuses or is unable to fulfill the warranty; and

(c) The respiratory care equipment or supply continues to be medically necessary.

(((~~12~~))) (10) If rental respiratory equipment or supplies must be replaced during the warranty period, the medicaid agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the respiratory equipment or supply provided to the client if:

(a) The provider is unwilling or unable to fulfill the warranty; and

(b) The respiratory care equipment or supply continues to be medically necessary.

(((~~13~~))) (11) The medicaid agency does not ((~~reimburse~~)) pay for respiratory care equipment and supplies, or related repairs and labor charges under FFS when the client is any of the following:

(a) An inpatient hospital client;

(b) Terminally ill and receiving hospice care; or

(c) Enrolled in a risk-based MCO that includes coverage for such items ((~~and/or~~)) or services, or both.

(((~~14~~))) (12) The medicaid agency rescinds any purchase order for a prescribed item if the equipment or supply was not supplied to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by an MCO.

(((~~15~~))) (13) See also WAC ((~~182-543-9100, 182-543-9200, 182-543-9300, and 182-543-9400~~)) 182-543-9000 for ((~~other~~)) general reimbursement ((~~methodologies~~)).

AMENDATORY SECTION (Amending WSR 12-14-022, filed 6/25/12, effective 8/1/12)

WAC 182-552-1600 Respiratory care equipment and supplies—Reimbursement—Methodology for purchase, rental, and repair. (1) The medicaid agency sets, evaluates, and updates the maximum allowable fees for ((~~purchased~~)) respiratory care equipment and supplies at least once yearly ((~~using one or more of the following:~~

~~(a) The current medicare rate, as established by the federal Centers for Medicare and Medicaid Services (CMS), for a new purchase if a medicare rate is available;~~

~~(b) A pricing cluster; or~~

~~(c) On a by-report basis.~~

~~(2)~~)), unless otherwise directed by the legislature or determined necessary by the agency.

(2) The agency sets the rates for medical equipment codes subject to the federal financial participation (FFP) limitation at the lesser of medicare's prevailing payment rates in the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or competitive bid area (CBA) rate. For all other procedure codes, the agency sets rates using one of the following:

(a) Medicare fee schedules;

(b) Legislative direction;

(c) Input from stakeholders or relevant sources that the agency determines to be reliable and appropriate;

(d) Pricing clusters; or

(e) A by-report (BR) basis.

(3) When there is only a rental rate on the DMEPOS fee schedule, the agency sets the maximum allowable purchase rate at either the DMEPOS rate divided by 0.15 or multiplied by ten. The agency sets the maximum allowable fee for daily rental at one three-hundredth of the new purchase price or one-thirtieth of the monthly rental rate on the DMEPOS fee schedule.

(4) When establishing ((~~reimbursement~~)) payment rates for ((~~purchased~~)) respiratory care equipment and supplies based on pricing clusters((~~.~~

~~(a) A pricing cluster is based on~~)) for a specific health care common procedure coding system (HCPCS) code((~~.~~

~~(b) The medicaid agency's~~)), the maximum allowable fee is the median or average amount of all items in the cluster. The pricing cluster is made up of all the brands/models for which the agency obtains pricing information. However, the ((~~medicaid~~)) agency may limit the number of brands/models included in the pricing cluster((~~. The medicaid agency considers all of the following when establishing the pricing cluster:~~

~~(i)~~)) due to any one or more of the following:

(a) A client's medical needs;

(((~~ii~~))) (b) Product quality;

(((~~iii~~))) (c) Introduction, substitution, or discontinuation of certain brands/models; (((~~iv) Cost; and/or~~

~~(v) Available alternatives.~~

~~(c) When establishing the fee for purchased respiratory care equipment and supplies in a pricing cluster, the maximum allowable fee is the median amount of available manufacturer's list or suggested retail prices for all brands/models as noted in (b) of this subsection.~~

~~(3) The medicaid agency evaluates items, procedures, and services billed using miscellaneous procedure codes, when an established code is not available, on a case-by-case basis for medical necessity, appropriateness, and reimbursement value. The medicaid agency calculates the purchase reimbursement rate for these items at eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year or the cost from the manufacturer's invoice.~~

~~(4) The medicaid agency's maximum allowable fees for monthly rental are updated at least once yearly and are established using one of the following:~~

~~(a) For items with a monthly rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency equates its maximum allowable fee for monthly rental to the current medicare monthly rental rate;~~

~~(b) For items that have a new purchase rate but no monthly rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency sets the maximum allowable fee for monthly rental at one-tenth of the new purchase price of the current medicare rate; or~~

~~(c) For items not included in the current medicare fee schedule, as established by CMS, the medicaid agency considers the maximum allowable monthly reimbursement rate as by-report. The medicaid agency calculates the monthly reimbursement rate for these items at one-tenth of eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year or one-tenth the cost from the manufacturer's invoice.~~

~~(5) The medicaid agency's maximum allowable fees for daily rental are updated at least once yearly and are established using one of the following:~~

~~(a) For items with a daily rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency equates its maximum allowable fee for daily rental to the current medicare daily rental rate;~~

~~(b) For items that have a new purchase rate but no daily rental rate on the current medicare fee schedule, as established by CMS, the medicaid agency sets the maximum allowable fee for daily rental at one three-hundredth of the new purchase price of the current medicare rate; or~~

~~(c) For items not included in the current medicare fee schedule, as established by CMS, the medicaid agency considers the maximum allowable daily reimbursement rate as by-report. The medicaid agency calculates the daily reimbursement rate for these items at one three-hundredth of eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year or one three-hundredth of the cost from the manufacturer's invoice~~)) or

(d) Cost.

(5) The agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness, and payment value on a case-by-case basis. The agency's payment rate is eighty percent of the manufacturer's list price or manufacturer's suggested retail price (MSRP), or one hundred percent of the wholesale acquisition cost (AC).

(6) The ((~~medicaid~~)) agency((~~, with prior authorization, will~~)) pay for repairs of client-owned equipment only, with prior authorization (PA). In addition to agency-specific forms identified in the agency's respiratory care ((~~medicaid provider~~)) billing guide, providers must meet all of the following requirements ((~~must be met in order~~)) to receive ((~~authorization~~)) PA and ((~~reimbursement~~)) payment for a repair of client-owned equipment:

(a) The provider must submit a manufacturer pricing sheet showing the manufacturer's list ((~~or suggested retail price (~~)) price, MSRP((~~)~~)), or manufacturer invoice showing the cost of the repair, identifying and itemizing the parts. The invoice must indicate the wholesale ((~~acquisition cost~~)) AC, the manufacturer's list price, or ((~~suggested retail price (~~))MSRP((~~)~~)) for all parts used in the repair for which ((~~reimbursement~~)) payment is being sought. ((~~Reimbursement for parts used in a repair will be:~~

~~(i) Eighty percent of the manufacturer's list or suggested retail price as of October thirty-first of the base year; or~~

~~(ii) The cost from the manufacturer's invoice.~~))

(b) ((~~Reimbursement for actual labor charges will be made according to the medicaid agency's current fee schedule.~~)) The provider must follow HCPCS coding guidelines and submit ((~~an authorization~~)) a PA request accordingly with actual labor units identified and supported by documentation.

(7) The agency pays for actual labor charges according to the agency's current fee schedule. The agency does not pay for base labor charges or other administrative-like fees ((~~will not be reimbursed~~)).

WSR 19-14-062
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed June 28, 2019, 11:08 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-12-030 and 18-12-031.

Title of Rule and Other Identifying Information: Chapter 182-532 WAC, Reproductive health services.

Hearing Location(s): On August 6, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Apple Conference Room 127, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner August 7, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by August 6, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by August 2, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is modifying the family planning only program and take charge program sections to: (1) Meet clinical standards, (2) align with current eligibility and provider enrollment policies, and (3) assure compliance with the recently approved federal extension of the Washington family planning only program (demonstration project) granted under the authority of section 1115(a) of the Social Security Act. The agency is modifying the reproductive health sections to meet clinical standards and align with current eligibility and provider enrollment policies.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160; Section 1115(a) of the Social Security Act.

Rule is necessary because of federal law, Section 1115(a) of the Social Security Act.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Crabbe, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9563; Implementation and Enforcement: Jamie Teuteberg, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1668.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The revisions to this rule do not impose additional compliance costs or requirements on providers.

June 28, 2019
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-001 Reproductive health services—Definitions. The following definitions and those found in ((~~WAC 182-500-0005~~)) chapter 182-500 WAC apply to this chapter.

340B dispensing fee - The medicaid agency's established fee paid to a registered and medicaid-participating 340B drug program provider under the public health service (PHS) act for expenses involved in acquiring, storing and dispensing prescription drugs or drug-containing devices (see WAC 182-530-7900). A dispensing fee is not paid for non-drug items, devices, or supplies (see WAC 182-530-7050).

"Complication" - A condition occurring subsequent to and directly arising from the family planning services received under the rules of this chapter.

"Comprehensive ((~~prevention visit for family planning~~)) preventive family planning visit" - For the purposes of this program, a comprehensive, preventive, contraceptive visit that includes evaluation and management of an individual, such as: Age appropriate history, examination, counseling/anticipatory guidance, risk factor reduction interventions, and ((~~labs~~)) laboratory and diagnostic procedures that are covered under the client's respective ((~~medicaid~~)) agency program. ((~~These services may only be provided by and paid to TAKE CHARGE providers.~~))

"Contraception" - Prevention of pregnancy through the use of contraceptive methods.

"Contraceptive" - ((~~A~~)) Food and Drug Administration (FDA)-approved prescription and nonprescription methods, including devices, drugs, products, methods, or surgical interventions used to prevent pregnancy, as described in WAC 182-530-2000.

((~~**"Delayed pelvic protocol" -** The practice of allowing a woman to postpone a pelvic exam during a contraceptive visit to facilitate the start or continuation of a hormonal contraceptive method.~~

~~**"Education, counseling and risk reduction intervention (ECRR)" -** Client-centered education and counseling services designed to strengthen decision-making skills and support a client's safe and effective use of a chosen contraceptive method. For women, ECRR is part of the comprehen-~~

~~sive prevention visit for family planning. For men, ECRR is a stand-alone service for those men who seek family planning services and whose partners are at moderate to high risk of unintended pregnancy.~~))

"Family planning only - Pregnancy related program" - The program that covers family planning only services for eligible clients for ten months following the sixty-day post pregnancy period.

"Family planning only program" - The program that ((~~provides an additional ten months of family planning services to eligible women at the end of their pregnancy. This benefit follows the sixty-day postpregnancy coverage for women who received medical assistance benefits during the pregnancy.~~

~~**"Family planning provider" -** For this chapter, a physician or physician's assistant, advanced registered nurse practitioner (ARNP), or clinic that, in addition to meeting requirements in chapter 182-502 WAC, is approved by the medicaid agency to provide family planning services to eligible clients as described in this chapter.~~)) covers family planning only services for eligible clients for twelve months from the date the agency determines eligibility. This program was formerly referred to as TAKE CHARGE.

"Family planning services" - Medically safe and effective medical care, educational services, ((~~and/or~~)) and contraceptives that enable individuals to plan and space the number of their children and avoid unintended pregnancies.

((~~**"Medicaid agency" -** Health care authority.~~))

"Natural family planning" (also known as fertility awareness method) - Methods to identify the fertile days of the menstrual cycle and avoid unintended pregnancies, such as observing, recording, and interpreting the natural signs and symptoms associated with the menstrual cycle.

"Over-the-counter (OTC)" - Drugs, devices, and products that do not require a prescription before they can be sold or dispensed and are approved by the Food and Drug Administration (FDA). (See WAC 182-530-1050((~~.~~)))

"Reproductive health" - The prevention and treatment of illness, disease, and disability related to the function of reproductive systems during all stages of life and includes:

(a) Related, appropriate, and medically necessary care;

(b) Education of clients in medically safe and effective methods of family planning; and

(c) Pregnancy and reproductive health care.

"Sexually transmitted infection (STI)" - A disease or infection acquired as a result of sexual contact.

((~~**"TAKE CHARGE" -** The medicaid agency's demonstration and research program approved by the federal government under a medicaid program waiver to provide family planning services.~~

~~**"TAKE CHARGE provider" -** A family planning provider who has a TAKE CHARGE agreement to provide TAKE CHARGE family planning services to eligible clients under the terms of the federally approved medicaid waiver for the TAKE CHARGE program. (See WAC 182-532-730 for provider requirements.)~~)))

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-050 Reproductive health services—((~~Purpose~~)) General. ((~~The medicaid agency defines reproductive health services as those services that:~~

~~(1) Assist clients to avoid illness, disease, and disability related to reproductive health;~~

~~(2) Provide related, appropriate, and medically necessary care when needed; and~~

~~(3) Assist clients to make informed decisions about using medically safe and effective methods of family planning.~~)) WAC 182-532-050 through 182-532-130 describe reproductive health services and related services covered by the medicaid agency. For maternity-related services, see chapter 182-533 WAC. For other related services, see chapter 182-531 WAC.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-100 Reproductive health services—((~~Client~~)) Eligibility. (1) The medicaid agency covers ((~~limited~~)) reproductive health services ((~~for clients eligible for the following:~~

~~(a) Children's health insurance program (CHIP);~~

~~(b) Categorically needy program (CNP);~~

~~(c) Medical care services (MCS) program;~~

~~(d) Limited casualty program-medically needy program (LCP-MNP); and~~

~~(e) Alcohol and Drug Abuse Treatment and Support Act (ADATSA) services~~)), as described under WAC 182-532-120, for clients covered by one of the Washington apple health programs as listed in the table in WAC 182-501-0060.

(2) A client((~~s~~)) enrolled in ((~~a medicaid~~)) an agency-contracted managed care organization (MCO) may self-refer outside their MCO for reproductive health care services including, but not limited to, family planning ((~~services (excluding sterilizations for clients twenty-one years of age or older)~~)), abortion((~~s~~)), and sexually transmitted infection (STI) services((~~. These clients may seek services from any of the following:~~

~~(a) A medicaid agency-approved family planning provider;~~

~~(b) A medicaid agency-contracted local health department/STI clinic;~~

~~(c) A medicaid agency-contracted provider for abortion services; or~~

~~(d) A medicaid agency-contracted pharmacy~~)) from any agency-approved provider.

(3) A client who is age twenty-one or older may not self-refer outside their MCO for sterilizations.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-110 Reproductive health services—Provider requirements. To ((~~be paid by the medicaid agency for reproductive health services provided to eligible clients, family planning providers, including licensed mid-~~

~~wives,~~)) receive payment for reproductive health services, a provider must:

(1) Meet the requirements ((~~in~~)) under this chapter and chapters 182-501 and 182-502 WAC;

(2) Provide only those services that are within the scope of their licenses;

(3) ((~~Comply with the required general medicaid agency and reproductive health provider policies, procedures, and administrative practices as detailed in the agency's billing instructions~~)) Bill the agency according to the agency's published billing guides;

(4) Educate clients on Food and Drug Administration (FDA)-approved prescription ((~~birth control~~)) contraceptive methods, as well as over-the-counter (OTC) ((~~birth control~~)) contraceptive drugs, devices, and supplies, and related medical services;

(5) Provide medical services related to FDA-approved prescription ((~~birth control~~)) contraceptive methods((~~,~~)) and OTC ((~~birth control~~)) contraceptive drugs, devices, and supplies upon request; and

(6) Supply or prescribe FDA-approved prescription ((~~birth control~~)) contraceptive methods((~~,~~)) and OTC ((~~birth control~~)) contraceptive drugs, devices, and supplies upon request.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-120 Reproductive health services—Covered ((~~yearly exams for women~~)) services. (((~~(1) Along with~~)) In addition to the services listed in WAC 182-531-0100, the medicaid agency covers ((~~one~~)) all of the following ((~~yearly exams per client per year:~~

~~(a) A cervical, vaginal, and breast cancer screening exam; or~~

~~(b) A comprehensive prevention visit for family planning. (Under a delayed pelvic protocol, the comprehensive prevention visit for family planning may be split into two visits, per client, per year.)~~

~~(2) The cervical, vaginal, and breast cancer screening examination:~~

~~(a) Must follow the guidelines of a nationally recognized protocol; and~~

~~(b) May be billed by a provider other than a TAKE CHARGE provider.~~

~~(3) The comprehensive prevention visit for family planning:~~

~~(a) Must be provided by one or more qualified TAKE CHARGE providers. (See WAC 182-532-730.)~~

~~(b) Must include:~~

~~(i) A clinical breast examination and pelvic examination that follows the guidelines of a nationally recognized protocol; and~~

~~(ii) Client-centered counseling that incorporates risk factor reduction for unintended pregnancy and anticipatory guidance about the advantages and disadvantages of all contraceptive methods.~~

~~(c) May include a pap smear according to current, nationally recognized clinical guidelines.~~

~~(d) Must be documented in the client's chart with detailed information that allows for a well-informed follow-up visit.~~

~~(e) Must be billed by a TAKE CHARGE provider only~~)) reproductive health services:

(1) For a client capable of reproducing, one comprehensive preventive family planning visit once every twelve months, based on nationally recognized clinical guidelines, including:

(a) Sexually transmitted infection (STI) and cancer screenings; and

(b) Comprehensive and client-centered counseling, education, risk reduction, and initiation or management of contraceptive methods.

(2) Contraception, including:

(a) Food and Drug Administration (FDA)-approved prescription and nonprescription contraceptive methods, as described under WAC 182-530-2000;

(b) Education and supplies for FDA-approved contraceptives, natural family planning, and abstinence; and

(c) Sterilization procedures, as described under WAC 182-531-1550.

(3) Cervical, breast, and prostate cancer screenings, according to nationally recognized clinical guidelines;

(4) STI screening, testing, and treatment, according to nationally recognized clinical guidelines;

(5) Human papillomavirus (HPV) immunization, administered according to the recommended schedule published by the Centers for Disease Control and Prevention (CDC);

(6) Diagnostic services, follow-up visits, imaging, and laboratory services related to the services listed under WAC 182-532-120; and

(7) Pregnancy-related services including:

(a) Maternity-related services, as described under chapter 182-533 WAC; and

(b) Abortion.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-130 Reproductive health services—Noncovered services. Noncovered reproductive health services are described in WAC 182-501-0070 and 182-531-0150.

FAMILY PLANNING ONLY PROGRAMS

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-500 Family planning only programs—Purpose. (((~~(1)~~))) The purpose of ((~~the~~)) family planning only programs is to provide family planning services to:

(((~~(a) Increase the healthy intervals between pregnancies; and~~

~~(b)~~))) (1) Improve access to family planning and family planning-related services;

(2) Reduce unintended pregnancies ((~~in women who received medical assistance coverage while pregnant.~~

~~(2) Women receive these services automatically, regardless of how or when the pregnancy ends. This ten-month cov-~~

~~erage follows the medicaid agency's sixty-day postpregnancy coverage.~~

~~(3) Men are not eligible for the family planning only program~~)); and

(3) Promote healthy intervals between pregnancies and births.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-510 Family planning only programs ~~((Client))~~ Eligibility. ((~~A woman is eligible for family planning only services if:~~

~~(1) She received medical assistance coverage during her pregnancy; or~~

~~(2) She is determined eligible for a retroactive period covering the end of the pregnancy.~~)) To be eligible for one of the family planning only programs listed in this section, a client must meet the qualifications for that program.

(1) **Family planning only - Pregnancy related program.**

(a) To be eligible for family planning only - Pregnancy related services, as defined in WAC 182-532-001, a client must be determined eligible for Washington apple health for pregnant clients during the pregnancy, or determined eligible for a retroactive period covering the end of a pregnancy. See WAC 182-505-0115.

(b) A client is automatically eligible for the family planning only - Pregnancy related program when the client's pregnancy ends.

(c) A client may apply for the family planning only program in subsection (2) of this section up to sixty days before the expiration of the family planning only - Pregnancy related program.

(2) **Family planning only program.**

(a) To be eligible for family planning only services, as defined in WAC 182-532-001, a client must:

(i) Be a United States citizen, U.S. National, or "qualified alien" as described under WAC 182-503-0535;

(ii) Provide a valid Social Security number (SSN) or meet good cause criteria listed in WAC 182-503-0515(2);

(iii) Be a Washington state resident, as described under WAC 182-503-0520;

(iv) Have an income at or below two hundred sixty percent of the federal poverty level, as described under WAC 182-505-0100;

(v) Need family planning services; and

(vi) Have been denied apple health coverage through www.wahealthplanfinder.org within the last thirty days, unless the applicant:

(A) Is age eighteen and younger and seeking services in confidence;

(B) Is a domestic violence victim who is seeking services in confidence; or

(C) Has an income of one hundred fifty percent to two hundred sixty percent of the federal poverty level, as described in WAC 182-505-0100.

(b) A client is not eligible for family planning only medical if the client is:

(i) Pregnant;

(ii) Sterilized;

(iii) Covered under another apple health program that includes family planning services; or

(iv) Covered by concurrent creditable coverage, as defined in RCW 48.66.020, unless they meet criteria in (a)(vi) of this subsection.

(c) A client may reapply for coverage under the family planning only program up to sixty days before the expiration of the twelve-month coverage period. The agency does not limit the number of times a client may reapply for coverage.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-520 Family planning only programs —Provider requirements. To be ((~~reimbursed~~)) paid by the medicaid agency for services provided to clients eligible for ((~~the~~)) family planning only programs, ((~~family planning~~)) providers must:

(1) Meet the requirements ((~~in~~)) under this chapter and chapters 182-501 and 182-502 WAC;

(2) Provide only those services that are within the scope of their licenses;

(3) ((~~Comply with the required general medicaid agency and family planning only provider policies, procedures, and administrative practices as detailed in the agency's billing instructions~~)) Bill the agency according to the agency's published billing guides;

(4) Educate clients on Food and Drug Administration (FDA)-approved prescription ((~~birth control~~)) contraceptive methods, as well as over-the-counter (OTC) ((~~birth control~~)) contraceptive drugs, devices, and supplies, and related medical services;

(5) Provide medical services related to FDA-approved prescription ((~~birth control~~)) contraceptive methods((~~,~~)) and OTC ((~~birth control~~)) contraceptive drugs, devices, and supplies as medically necessary;

(6) Supply or prescribe FDA-approved prescription ((~~birth control~~)) contraceptive methods((~~,~~)) and OTC ((~~birth control~~)) contraceptive drugs, devices, and supplies as medically appropriate; and

(7) Refer the client to available and affordable nonfamily planning primary care services, as needed.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-530 Family planning only programs —Covered ((~~yearly exams~~)) services. (((~~1~~))) The medicaid agency covers ((~~one~~)) all of the following services ((~~per client per year, as medically necessary:~~

~~(a) A cervical, vaginal, and breast cancer screening exam; or~~

~~(b) A comprehensive prevention visit for family planning. (Under a delayed pelvic protocol, the comprehensive prevention visit for family planning may be split into two visits, per client, per year.)~~

~~(2) The cervical, vaginal, and breast cancer screening exam:~~

~~(a) Must be:~~

~~(i) Provided following the guidelines of a nationally recognized protocol; and~~

~~(ii) Conducted at the time of an office visit with a primary focus and diagnosis of family planning.~~

~~(b) May be billed by a provider other than a TAKE CHARGE provider.~~

~~(3) The comprehensive prevention visit for family planning:~~

~~(a) Must be provided by one or more qualified TAKE CHARGE trained providers. (See WAC 182-532-730.)~~

~~(b) Must include:~~

~~(i) A clinical breast examination and pelvic examination that follows the guidelines of a nationally recognized protocol; and~~

~~(ii) Client-centered counseling that incorporates risk factor reduction for unintended pregnancy and anticipatory guidance about the advantages and disadvantages of all contraceptive methods.~~

~~(c) May include:~~

~~(i) A pap smear according to current, nationally recognized clinical guidelines; and~~

~~(ii) For women ages thirteen through twenty-five, routine gonorrhea and chlamydia testing and treatment.~~

~~(d) Must be documented in the client's chart with detailed information that allows for a well informed follow-up visit.~~

~~(e) Must be billed by a TAKE CHARGE provider only~~)):

(1) One comprehensive preventive family planning visit once every twelve months, based on nationally recognized clinical guidelines. This visit must have a primary focus and diagnosis of family planning and include counseling, education, risk reduction, and initiation or management of contraceptive methods;

(2) Assessment and management of family planning or contraceptive problems, when medically necessary;

(3) Contraception, including:

(a) Food and Drug Administration (FDA)-approved prescription and nonprescription contraceptive methods, as described under WAC 182-530-2000;

(b) Education and supplies for Federal Drug Administration (FDA)-approved contraceptive, natural family planning, and abstinence; and

(c) Sterilization procedures, as described under WAC 182-531-1550.

(4) The following services, when appropriate, during a visit focused on family planning:

(a) Pregnancy testing;

(b) Cervical cancer screening, according to nationally recognized clinical guidelines;

(c) Gonorrhea and chlamydia screening and treatment for clients age thirteen through twenty-five, according to nationally recognized clinical guidelines;

(d) Syphilis screening and treatment for clients who have an increased risk for syphilis, according to nationally recognized guidelines; and

(e) Sexually transmitted infection (STI) screening, testing, and treatment, when medically indicated by symptoms or report of exposure, and medically necessary for the client's safe and effective use of their chosen contraceptive method.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-550 Family planning only programs ~~((Reimbursement and))~~ Payment limitations. (1) The medicaid agency limits ((~~reimbursement~~)) payment under the family planning only programs to services that:

(a) Have a primary focus and diagnosis of family planning as determined by a qualified licensed medical practitioner; and

(b) Are medically necessary for the client to safely and effectively use, or continue to use, ((~~her~~)) the client's chosen contraceptive method.

(2) The ((~~medicaid~~)) agency ((~~reimburses~~)) pays:

(a) Providers for covered family planning ((~~only~~)) services using the agency's published fee schedules((~~.~~

~~(3)~~));

(b) For family planning pharmacy services, family planning ((~~lab~~)) laboratory services, and sterilization services ((~~are reimbursed by the medicaid agency under the rules and fee schedules applicable to these specific programs.~~

~~(4) The medicaid agency pays~~)) using the agency's published fee schedules; and

(c) A dispensing fee only for contraceptive drugs ((~~that are~~)) purchased through the 340B program of the Public Health Service Act. (See chapter 182-530 WAC((~~.~~)))

(((~~(5) Under WAC 182-501-0200, the medicaid agency requires a provider to~~)) (3) The agency does not pay for inpatient services under the family planning only programs, except for complications arising from covered family planning services.

(4) The agency requires providers to:

(a) Meet the timely billing requirements of WAC 182-502-0150; and

(b) Seek timely reimbursement from a third party when a client has available third-party resources, as described under WAC 182-501-0200. ((~~The~~)) Exceptions to this requirement are described under WAC 182-501-0200 (2) and (3) and 182-532-570.

(5) Services provided to family planning clients by federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health care providers (IHCP) do not qualify for encounter or enhanced rates.

NEW SECTION

WAC 182-532-560 Family planning only programs —Documentation requirements. In addition to the requirements in WAC 182-502-0020, providers must document the following in the client's medical record:

(1) Primary focus and diagnosis of the visit is family planning related;

(2) Contraceptive methods discussed;

(3) Plan for use of a contraceptive method, or the reason and plan for no contraceptive method;

(4) Education, counseling, and risk reduction with sufficient detail that allows for follow-up;

(5) Referrals to, or from, other providers; and

(6) If applicable, a copy of the completed consent form for sterilization. (See WAC 182-531-1550)

NEW SECTION

WAC 182-532-570 Family planning only programs —Good cause exemption from billing third-party insurance. (1) For the purposes of this section, "good cause" means that the use of the third-party coverage would violate a client's confidentiality because the third party:

(a) Routinely sends written, verbal, or electronic communications, as defined in RCW 48.43.505, to the third-party subscriber and that subscriber is someone other than the client; or

(b) Requires the client to use a primary care provider who is likely to report the client's request for family planning services to the subscriber.

(2) Clients eligible for family planning only programs may request an exemption from the requirement to bill third-party insurance due to "good cause" if they are:

(a) Eighteen years of age or younger and seeking services in confidence; or

(b) Domestic violence victims and seeking services in confidence.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-532-123	Reproductive health—Other covered services for women.
WAC 182-532-125	Reproductive health—Covered services for men.
WAC 182-532-533	Family planning only program—Other covered services.
WAC 182-532-540	Family planning only program—Noncovered services.
WAC 182-532-700	TAKE CHARGE program—Purpose.
WAC 182-532-720	TAKE CHARGE program—Eligibility.
WAC 182-532-730	TAKE CHARGE program—Provider requirements.
WAC 182-532-740	TAKE CHARGE program—Covered yearly exams for women.
WAC 182-532-743	TAKE CHARGE program—Other covered services for women.
WAC 182-532-745	TAKE CHARGE program—Covered services for men.
WAC 182-532-750	TAKE CHARGE program—Noncovered services.
WAC 182-532-760	TAKE CHARGE program—Documentation requirements.
WAC 182-532-780	TAKE CHARGE program—Reimbursement and payment limitations.
WAC 182-532-790	TAKE CHARGE program—Good cause exemption from billing third party insurance.

WSR 19-14-089
WITHDRAWAL OF PROPOSED RULES
DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

[Filed July 1, 2019, 10:35 a.m.]

The department of children, youth, and families withdraws WSR 19-09-076, working connections and seasonal child care subsidy, WAC 110-15-0277 Provider program violations and suspected fraud and 110-15-0279 Program violation sanctions.

Please contact Brenda Villarreal at 360-902-7956 if you have any questions or need anything further.

Brenda Villarreal
Rules Coordinator

WSR 19-14-095
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2019-01 — Filed July 1, 2019, 2:42 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-06-043.

Title of Rule and Other Identifying Information: The following sections in chapter 182-08 WAC are revised or new: WAC 182-08-015 Definitions, 182-08-120 Employer contribution, 182-08-180 Premium payments and premium refunds, 182-08-185 What are the requirements regarding premium surcharges?, 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment?, 182-08-190 The employer contribution is set by the health care authority (HCA) and paid to the HCA for all eligible employees, 182-08-191 (new) Subscriber address requirements, 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare?, 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete required forms?, 182-08-198 When may a subscriber change health plans?, 182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)?, 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment or for faculty employed by more than one institution of higher education?, 182-08-235 Employer group and charter school application

process, and 182-08-245 Employer group and charter school participation requirements.

The following sections in chapter 182-12 WAC are revised: WAC 182-12-109 Definitions, 182-12-111 Which entities and individuals are eligible for public employees benefits board (PEBB) benefits?, 182-12-113 What are the obligations of a state agency in the application of employee eligibility?, 182-12-114 How do employees establish eligibility for public employees benefits board (PEBB) benefits?, 182-12-116 Who is eligible to participate in the salary reduction plan?, 182-12-123 Is dual enrollment prohibited?, 182-12-128 When may an employee waive enrollment in public employee benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment?, 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) insurance coverage?, 182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff?, 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)?, 182-12-141 If an employee reverts from an eligible position, what happens to their public employees benefits board (PEBB) insurance coverage?, 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility?, 182-12-146 When is an enrollee eligible to continue public employee's benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA)?, 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal?, 182-12-171 When is a retiring employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage?, 182-12-180 When is an elected and full-time appointed official of the legislative and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage?, 182-12-200 May a retiring employee or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state school district, a Washington state educational service district, or a Washington state charter school defer PEBB health plan enrollment under PEBB retiree insurance coverage?, 182-12-205 May a retiree or a survivor defer or voluntarily terminate public employees benefits board (PEBB) health plan enrollment under PEBB retiree insurance coverage?, 182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be terminated by the health care authority (HCA)?, 182-12-209 Who is eligible for retiree term life insurance?, 182-12-211 May an employee who is determined to be retroactively eligible for disability retirement enroll in public employees benefits board (PEBB) retiree insurance coverage?, 182-12-260 Who are eligible dependents?, 182-12-262 When may subscribers enroll or remove eligible dependents?, 182-12-263 National Medical Support Notice (NMSN), 182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if the employee or retiree dies?, 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260?, and 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements.

The following sections in chapter 182-16 WAC are revised: WAC 182-16-010 Purpose, 182-16-020 Definitions, 182-16-055 Mailing address changes, 182-16-064 Applicable rules and laws, 182-16-066 Burden of proof, standard of proof, and presumptions, 182-16-120 Computation of time, 182-16-130 Index of significant decisions, 182-16-2000 Brief adjudicative proceedings, 182-16-2010 Where to appeal a decision regarding eligibility, enrollment, premium payments, premium surcharges, a public employees benefits board (PEBB) wellness incentive, or the administration of benefits?, 182-16-2020 How can a current or former employee or an employee's dependent appeal a decision made by a state agency about eligibility, premium surcharge, or enrollment in benefits?, 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group, 182-16-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements?, 182-16-2050 How can an employee who is eligible to participate in the state's salary reduction plan appeal a decision regarding the administration of benefits offered under the state's salary reduction plan?, 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application?, 182-16-2080 Who can appeal or represent a party in a brief adjudicative proceeding?, 182-16-2085 Continuances, 182-16-2090 Initial order, 182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding, 182-16-2105 Withdrawing the request for a brief adjudicative proceeding or review of an initial order, 182-16-2120 Request for reconsideration, 182-16-2130 Judicial review of final order, 182-16-2140 Presiding officer—Designation and authority, 182-16-2150 Review officer or officers—Designation and authority, 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing, 182-16-3000 Formal administrative hearings, 182-16-3010 Requirements to appear and represent a party in the formal administrative hearing process, 182-16-3030 Authority of the hearing officer, 182-16-3080 Time requirements for service of notices made by the hearing officer, 182-16-3100 Rescheduling and continuances for formal administrative hearings, 182-16-3120 Dispositive motions, 182-16-3130 Subpoenas, 182-16-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal, 182-16-3160 Withdrawing a formal administrative hearing, 182-16-3170 Final order deadline—Required information, 182-16-3180 Request for reconsideration and response—Process, 182-16-3190 Decisions on requests for reconsideration, and 182-16-3200 Judicial review of final order.

Hearing Location(s): On August 6, 2019, at 10:00 a.m. at the HCA, Cherry Street Plaza, Apple Conference Room 127, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is avail-

able at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than August 7, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by August 6, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by August 2, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to create new rules and to amend some of the existing rules to support the PEBB program.

1. Implement PEBB policy resolutions:

- Amended WAC 182-08-187 to allow an error correction if an employing agency provides incorrect information regarding PEBB program benefits to the employee that they relied upon, and at a minimum the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified;
- Amended WAC 182-12-205 to clarify a subscriber may defer PEBB retiree insurance coverage due to enrollment in CHAMPVA;
- Amended WAC 182-12-209 to include PEBB retiree term life insurance eligibility for an eligible school employee who participates in the SEBB program's life insurance;
- Amended WAC 182-12-300 to include new deadlines for completing wellness activities.

2. Make technical amendments:

- Amended WAC 182-08-190, 182-12-131, and 182-12-138 to include requirements for the paid family and medical leave program;
- Amended WAC 182-08-198 to include a special open enrollment event must be an event other than an employee gaining initial eligibility, and to include an exception related to the availability of a dental plan, and to explain the consequences of a subscriber not making a new health plan selection when moving to a new location;
- Amended WAC 182-08-199 to include the requirement that the change in residence results in the dependent losing their health insurance when the dependent moves into or out of the United States, to include the requirement that the change in residence results in the dependent losing their health insurance, and to clarify the disruption of care life event;
- Amended WAC 182-12-111 to remove references related to school districts and charter schools, and amended to include educational service districts for their nonrepresented employees through December 31, 2023;
- Amended WAC 182-12-116 to remove charter school;
- Amended WAC 182-12-171, 182-12-200, 182-12-205, 182-12-211, and 182-12-265 to include retiring school employee and to remove school district and charter school;
- Amended WAC 182-12-262 to change notification requirements for removing a dependent who loses eligibility, to adjust the amount of time for subscribers to provide notice from twelve months to no more than sixty days for adding a newborn or a child based on adoption, to clarify when a dependent's PEBB insurance coverage will begin and end, and to add corresponding WAC references for different types of enrollees;
- Amended WAC 182-16-055 to replace existing WAC with WAC 182-08-191;
- Amended WAC 182-16-064 to include that an employing agency must follow PEBB program rules and instructions from the HCA;
- Amended WAC 182-16-066 to include that the appellant has the burden of proof in a brief adjudicative proceeding or a formal administrative hearing;
- Amended WAC 182-16-120 to clarify that the time prescribed is ten days or less;
- Amended WAC 182-16-2000 and 182-16-3000 with the correct RCW citation;
- Amended WAC 182-16-2010 to correct PEBB benefits' and PEBB appeals unit's descriptions;
- Amended WAC 182-16-2020 to require the state agency to perform a complete review of the denial, removed the language that the state agency may hold a formal meeting or formal administrative hearing, included when the request for administrative review may be considered denied, and removed language related to the state agency may reverse eligibility, premium surcharges, or enrollment decisions based on circumstances with a WAC reference;
- Amended WAC 182-16-2100 to include the written or oral request for review of the initial order must be made by using the contact information include[d] in the initial order and to clarify the authority may review an order resulting from;
- Amended WAC 182-16-2160 with the correct RCW citation and to clarify the director designates a hearing officer to conduct the formal administrative hearing;
- Amended WAC 182-16-3080 and 182-16-3100 to correct notice requirements and rescheduling requirement references;
- Amended WAC 182-16-3130 to detail who may request the hearing officer quash or change a subpoena request at any time before the deadline given in the subpoena;
- Amended WAC 182-16-3190 to correct a WAC reference and to clarify if the request for reconsideration is granted issuing a new written final order; and
- Amended WAC 182-16-3200 with the correct RCW citations.

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

- Within the definitions sections of chapters 182-08, 182-12, and 182-16 WAC:
  - Amended the definition of "life insurance" to remove the reference to accidental death and dis-

memberment (AD&D) insurance and created a new definition for "AD&D";
- Amended the definition of "calendar days or days" to include all legal state holidays as described in RCW 1.16.050;
- Amended the definition of "dependent care assistance program or DCAP" to reflect the correct statute and to incorporate who may participate;
- Amended the definition of "employee" to include nonrepresented educational service districts' employees and to remove employees of employee organizations currently pooled with employees of school districts;
- Amended the definition of "employer group" to clarify school districts and charter schools could enter in contractual agreement through December 31, 2019; and educational service districts could enter in contractual agreement through December 31, 2023 with HCA;
- Amended the definition of "employing agency" to remove school district and educational service district;
- Amended the definition of "long-term disability insurance or LTD insurance" to clarify supplemental long-term disability insurance offered to and paid for by the employee;
- Amended the definition of "medical flexible spending arrangement or medical FSA" to correct statute reference and to match with statute;
- Amended the definition of "PEBB insurance coverage" to include accidental death and dismemberment insurance;
- Amended the definition of "premium payment plan" to include state statute's and federal regulations' references;
- Amended the definition of "premium surcharge" to clarify that it is the PEBB uniform medical plan;
- Created new definitions of "forms or form," "public employee," and "state registered domestic partner";
- Amended the definition of "salary reduction plan" to match with statute;
- Amended the definition of "state agency" for an error correction;
- Amended the definition of "subscriber" to clarify a subscriber is enrolled in PEBB benefits;
- Amended the definition of "waive" to clarify an eligible employee affirmatively declining enrollment in a PEBB health plan;

- Within the definitions sections of chapters 182-08 and 182-12 WAC:
  - Amended the definitions of "annual open enrollment" and "continuation coverage" for clarity;
  - Amended the definition of "employer contribution" to remove charter school;
  - Amended the definition of "employer-paid coverage" to remove charter school and include SEBB insurance coverage for which an employer contribution is made by a SEBB organization;
  - Created a new definition of "supplemental coverage";
- Within the definitions section of chapter 182-12 WAC:
  - Amended the definition of "seasonal employee" to match with statute;
  - Created new definitions of "school employee," "SEBB," "SEBB insurance coverage," and "SEBB organization";
- Amended the following definitions in WAC 182-16-020:
  - Amended the definition of "appellant" to clarify it is a person who requests a brief adjudicative proceeding with the PEBB appeals unit;
  - Amended the definition of "brief adjudicative proceeding" to include WAC references;
  - Amended the definition of "denial" or "denial notice" to include contracted vendor;
  - Created a new definition of "dispositive motion";
  - Amended the definition of "final order" to clarify an order that is the final HCA's decision.
  - Amended the definition of "formal administrative hearing" to include statute and WAC references;
- Amended WAC 182-08-180 to clarify that the PEBB insurance coverage premiums and applicable premium surcharges are due for all subscriber[s], to include HCA may develop a reasonable payment plan of up to twelve months in duration upon subscriber or subscriber's legal representative's request, to clarify under what circumstances the PEBB director, the PEBB director's designee, or the PEBB appeals unit may approve a premium refund, to add the PEBB director, the PEBB director's designee, or the PEBB appeals unit may approve an enrollment change that was originally requested and which forms the basis for a refund, and to clarify employing agency errors will be corrected with corresponding WAC references;
- Amended WAC 182-08-185 to clarify premium surcharge is in addition to the medical premium, to clarify medicare risk pool by adding a corresponding statute, and to clarify when an employee or a subscriber may attest for the spousal premium surcharge;
- Amended WAC 182-08-187 to clarify an enrollment error for failure to enroll an employee and their dependents in PEBB insurance coverage;
- Amended WAC 182-08-190 to remove charter school and to clarify the employer contributions must be paid to HCA;
- Created WAC 182-08-191 to include employees and subscribers' address requirements;
- Amended WAC 182-08-196 to clarify when a subscriber must elect a new health plan when their previously selected health plan becomes unavailable and when they submit the required forms and consequences of not making a new election;
- Amended WAC 182-08-197 to clarify when an employee may enroll in supplemental coverage and what coverage an employee may be defaulted to when the employing agency or contracted vendor did not receive the required forms within thirty-one days;
- Amended WAC 182-08-200 to clarify which employing agency is responsible for employer contribution when an employee changes employment;

- Amended WAC 182-08-235 and 182-08-245 to remove charter school and school districts, and to include educational service districts as employer groups applying for their nonrepresented employees;
- Amended WAC 182-12-113 to include state agencies must determine employee's dependents eligibility for PEBB benefits and to clarify state agencies must inform the employee their right to appeal when they are ineligible for benefits and the employer contribution due to a change in work patterns;
- Amended WAC 182-12-114 to clarify when employees, seasonal employees, and faculty are eligible for PEBB benefits through stacking;
- Amended WAC 182-12-123 to include PEBB in the title for clarity, to include a WAC reference when the PEBB program will terminate the employee's enrollment as a dependent, and to remove health plan sponsored by school district and charter school and replace them with SEBB;
- Amended WAC 182-12-128 to clarify a special enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits, to clarify if an employee waives PEBB medical the employee may not enroll dependents into PEBB medical, to include WAC 182-12-262 reference when referring to the dependents' effective date of PEBB medical, and to include the requirement that the change in residence results in the dependent losing their health insurance when the dependent moves into or out of the United States;
- Amended WAC 182-12-133 to change references from PEBB insurance coverage to PEBB benefits;
- Amended WAC 182-12-146 to restructure this section for clarity, to include additional WAC references when clarifying COBRA eligibility for a retiree or a retiree's dependent, to make a technical correction from an employee's to a subscriber's state registered domestic partner in the note section of subsection (6), to clarify when COBRA coverage will end, and to clarify a COBRA-eligible employee can continue medical FSA if they have a greater amount in remaining benefits than remaining contribution payments for the current year;
- Amended WAC 182-12-148 to clarify HCA will refund premiums and applicable premium surcharges the employee paid when the employer contribution is reinstated;
- Amended WAC 182-12-171 to include PEBB retiree insurance coverage enrollment when referencing first premium payment;
- Amended WAC 182-12-211 to include defer enrollment in the title, to clarify the date of enrollment or deferment in PEBB retiree insurance coverage must be indicated on the form, to add a new subsection to indicate premiums and applicable premium surcharges are due from the effective date of enrollment;
- Amended WAC 182-12-260 to include notice requirements for an employee when a dependent is no longer eligible, to include WAC references for retirees, survivors, and PEBB continuation coverage enrollees, to clarify when PEBB insurance coverage will end, to include when enrollment of an extended dependent or a dependent with a disability will begin and to make a technical correction and replace health plan references with PEBB benefits;
- Amended WAC 182-12-263 to clarify subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the PEBB program;
- Amended WAC 182-12-265 to include survivors of school employee and a note regarding a spouse, state registered domestic partner, or child of an eligible school employee enrolled in SEBB insurance coverage may continue health plan enrollment as described in WAC 182-31-090;
- Amended WAC 182-12-270 to make error corrections and moved existing language to a new subsection (3) for clarity;
- Amended WAC 182-12-300 to include a statute when describing medicare risk pool and to make an error correction;
- Amended WAC 182-16-2105 to clarify procedures after a withdrawal request is received;
- Amended WAC 182-16-2030, 182-16-2040, 182-16-2050, 182-16-2060 regarding PEBB appeals unit's notification;
- Amended WAC 182-16-2050 regarding state agency's requirements when handling a salary reduction plan's appeal;
- Amended WAC 182-16-2080 and 182-16-3010 to clarify when HCA employees may represent an appellant;
- Amended WAC 182-16-2100 to clarify that when requesting for reconsideration, the request can be made written or orally and is subject to be granted in a written final order;
- Amended WAC 182-16-2130 to clarify the RCW references when filing a written petition for judicial review and to include the PEBB program and the employing agency may not request judicial review;
- Amended WAC 182-16-3030 to remove de novo (anew);
- Amended WAC 182-16-3120 about entering an order dismissing the dispositive motion;
- Amended WAC 182-16-3140 to clarify if no request is received [by] the deadline, the dismissal order becomes HCA's final decision without further action;
- Amended WAC 182-16-3160 to clarify which hearing representative an appellant may contact to withdraw a formal administrative hearing;
- Amended WAC 182-16-3180 to clarify the party filing the request for reconsideration must serve copies of the request on all other parties on the same day the request is served on the hearing officer, and to clarify the exception when no evidence may be offered in support of a motion for reconsideration;
- Amended WAC 182-16-3190 to clarify a new written final order is issued if the request is granted and to correct a WAC citation reference.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: ESHB 2140, SSB 5975, and ESSB 6241.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0880; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

July 1, 2019
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

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

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

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

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

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

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of health plan coverage available to enrollees ((~~after a qualifying event occurs as administered~~)) under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or ((~~PEBB insurance coverage extended by~~)) the public employees benefits ((~~board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270~~)) board's policies.

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

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

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

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby ((~~state and public~~)) employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing

state civil service employees, at the option of each such employee organization((~~, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization~~)); (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); ((~~and~~)) (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

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

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

"Employer contribution" means the funding amount paid to the ((~~authority~~)) HCA by a state agency((~~,~~)) or employer group((~~, or charter school~~)) for its eligible employees as described ((~~in~~)) under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, ((~~school districts, educational service districts, and~~)) employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

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

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

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, ((~~school district, educational service district,~~)) or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

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

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

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

"Forms" or "form" means both paper forms and forms completed electronically.

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

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of $50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

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

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

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

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

"Long-term disability insurance" or "LTD insurance" ((~~includes~~)) means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to ((~~employees on an optional basis~~)) and paid for by the employee.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state ((~~and public~~)) employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

"PEBB" means the public employees benefits board.

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

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

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby ((~~state and~~)) public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

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

"Public employee" has the same meaning as employee.

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

"Salary reduction plan" means a benefit plan whereby ((~~state and~~)) public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program ((~~(DCAP)~~)), medical flexible spending arrangement ((~~(FSA)~~)), or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government ((~~and all personnel thereof~~)). It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, ((~~or charter school~~)) is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee((~~s~~)).

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the employee in addition to the coverage provided by the employing agency.

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

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

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

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

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

WAC 182-08-120 Employer contribution for the public employees benefits board (PEBB) benefits. The employer contribution must be used to provide public employees benefits board (PEBB) insurance coverage for the basic life insurance benefit, basic accidental death and dismemberment insurance benefit (AD&D), the basic long-term disability (LTD) insurance benefit, medical ((~~and~~)) insurance, dental insurance, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverage for employees employed by state agencies.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-180 Premium payments and premium refunds. Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all subscribers are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 ((~~(3)~~)) (4) or ((~~(4)~~)) (5).

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

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

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), 182-12-211, and 182-12-265; or electing to enroll in continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270, the first premium payment and applicable premium surcharges are due to the health care authority (HCA) no later than forty-five days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life insurance and accidental death and dismemberment insurance coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

(b) For employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the employing agency. If an employee elects ((~~optional~~)) supplemental coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the ((~~optional~~)) supplemental coverage begins.

(c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the HCA. For subscribers not eligible for the employer contribution or employees eligible for the employer contribution as described in WAC 182-12-138, monthly premiums or applicable premium surcharges that remain unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain unpaid for sixty days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. If it is determined by the HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the HCA may develop a reasonable payment plan of up to twelve months in duration with the subscriber or the subscriber's legal representative upon request.

(d) Monthly premiums or applicable premium surcharges due from a subscriber who is not eligible for the employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premiums or applicable premium surcharges are received by the HCA and the monthly premiums or applicable premium surcharges remain unpaid for thirty days; or

(ii) Premium payments or applicable premium surcharges received by the HCA are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain underpaid for thirty days past the date the monthly premiums or applicable premium surcharges were due.

(2) **Premium refunds.** PEBB insurance coverage premiums and applicable premium surcharges will be refunded using the following methods:

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

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC 182-16-2010, ((~~showing proof~~)) and provides clear and convincing evidence of extraordinary circumstances ((~~beyond their control~~)), such that ((~~it was effectively impossible to~~)) the subscriber could not timely submit the necessary information to accomplish an allowable enrollment change within sixty days

after the event that created a change of premiums, the PEBB director, the PEBB director's designee, or the PEBB appeals unit may:

(i) Approve a refund of premiums and applicable premium surcharges which does not exceed twelve months of premiums; and

(ii) Approve the enrollment change that was originally requested and which forms the basis for the refund.

(c) If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, medicare) the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time they were enrolled under the federal program if approved by the PEBB director or the director's designee.

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

(e) Employing agency errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employee or beneficiary as described in WAC 182-08-187 (4) and (5).

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical, the subscriber must update their attestation on the required form. An employee must submit the form to their employing agency. Any other subscriber must submit their form to the PEBB program. The attestation change will apply as follows:

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

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

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

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The enrollee must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(v) An employee or retiree who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), or 182-12-211, must provide an attestation on the required form if they have not previously attested as described in (a) of this subsection. The employee or retiree must submit their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vi) A surviving spouse, state registered domestic partner, or dependent child, thirteen years and older, who enrolls in PEBB medical as described in WAC 182-12-180 (3)(a), 182-12-250(5) or 182-12-265, must provide an attestation on the required form to the PEBB program if they have not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

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

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

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

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

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

(i) An enrollee who is eighteen years and older and uses tobacco products is currently enrolled in the free tobacco cessation program through their PEBB medical.

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

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

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly medical premium, if an enrolled spouse or state registered domestic partner ((~~elected~~)) has chosen not to enroll in another employer-based group medical where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB Uniform Medical Plan (UMP) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

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

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

(ii) ((~~When a special open enrollment event occurs as described in WAC 182-12-262 (1)(c). A subscriber must submit the required form to enroll a spouse or state registered domestic partner in PEBB medical. The subscriber must include their attestation on that form. An employee must submit the form to their employing agency. Any other subscriber must submit the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;~~

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

• Incurring the surcharge;

• Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through their employer-based group medical was more than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the PEBB UMP Classic; or

• Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the PEBB UMP Classic's benefits.

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

((~~(iv)~~)) (iii) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must update their attestation on the required form. An employee must submit the form to their employing agency no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes. Any other subscriber must submit the form to the PEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes.

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

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

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool as described in RCW 41.05.080(3) is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

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

(3) An employee who covers their spouse or state registered domestic partner who has waived their own PEBB medical must attest as described in this subsection, but will not incur a premium surcharge ((~~will not be applied~~)) if the employee provides an attestation that their spouse or state registered domestic partner is eligible for PEBB coverage.

(4) A subscriber who covers their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest as described in this subsection, but will not incur a premium surcharge ((~~will not be applied~~)) if the subscriber provides an attestation that their spouse or state registered domestic partner is eligible for a TRICARE plan.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there

a limit on retroactive enrollment? (1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (4) of this section.

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

(b) Failure to enroll the employee and their dependents in PEBB insurance coverage as elected by the employee, if the elections were timely;

(c) Failure to enroll an employee and their dependents in PEBB insurance coverage as described in WAC 182-08-197 (1)(b);

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

(e) Enrolling an employee or their dependent((~~s~~)) in PEBB insurance coverage when they are not eligible as described in WAC 182-12-114 or 182-12-260 and it is clear there was no fraud or intentional misrepresentation by the employee involved((~~.~~)); or

(f) Providing incorrect information regarding PEBB benefits to the employee that they relied upon.

(2) The employing agency or the applicable contracted vendor must enroll the employee and the employee's dependents, as elected, or terminate enrollment in PEBB benefits as described in subsection (((~~(2)~~))) (3) of this section, reconcile premium payments and applicable premium surcharges as described in subsection (((~~(3)~~))) (4) of this section, and provide recourse as described in subsection (((~~(4)~~))) (5) of this section.

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

(((~~(2)~~))) (3) **Enrollment or termination.**

(a) PEBB medical and dental enrollment is effective at a minimum the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection (((~~(4)~~))) (5) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

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

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

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

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

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

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in a medical FSA or DCAP as elected, the employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect((~~.~~));

(e) If the employee or their dependent was not eligible but still enrolled as described in subsection (1)(e) of this section, the employee's or their dependent's PEBB insurance coverage will be terminated prospectively effective as of the last day of the month.

(((~~(3)~~))) (4) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, applicable premium surcharges, basic life, basic AD&D, and basic LTD ((~~from~~)) starting the date PEBB insurance coverage begins as described in subsections (((~~(2)~~))) (3) and (((~~(4)~~))) (5)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of their eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and applicable premium surcharges for coverage for months following notification of a new enrollment period.

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

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

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

(c) When an employing agency mistakenly enrolls an employee or their dependent as described in subsection (1)(e) of this section, premiums and any applicable premium surcharges will be refunded by the employing agency to the employee without rescinding the insurance coverage.

(((~~4~~))) (5) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection (((~~2~~))) (3) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

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

(iv) Other legal remedy received or offered; or

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

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

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

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

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

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

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

(4) Employees of employer groups ((~~and charter schools~~)) eligible under criteria stipulated under contract with the HCA are eligible for the employer contribution.

(5) The entire employer contribution is due and payable to the HCA even if PEBB medical is waived as described in WAC 182-12-128.

(((~~5~~))) (6) Washington state patrol officers disabled while performing their duties as determined by the chief of the Washington state patrol are eligible for the employer contribution for PEBB medical as authorized in RCW 43.43.040. No other retiree or disabled employee is eligible for the employer contribution for PEBB benefits unless they are an eligible employee as described in WAC 182-12-114 or 182-12-131.

(((~~6~~))) (7) The terms of payment to HCA for employer groups ((~~and charter schools~~)) shall be stipulated under contract with the HCA.

NEW SECTION

WAC 182-08-191 Subscriber address requirements. (1) All employees must provide their employing agency with their correct address and update their address if it changes. A subscriber on PEBB retiree insurance coverage or continuation coverage must provide the PEBB program with their correct address and updates to their address if it changes.

(2) Employees who are appealing a decision to the public employees benefits board (PEBB) program must update their address as required in WAC 182-16-055.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) A subscriber((~~s~~)) must ((~~select~~)) elect a new health plan ((~~within sixty days of~~)) when their ((~~chosen~~)) previously selected health plan ((~~becoming~~)) becomes unavailable due to a change in contracting service area ((~~or the subscriber or subscriber's dependent ceasing to be eligible for their current plan because of their enrollment in medicare.~~

~~(a) Employees~~)) as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than sixty days after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(((~~(b) All~~))) (ii) Any other subscriber((~~s~~)) must submit the required forms to ((~~notify~~)) the PEBB program electing their new health plan.

(((~~(c)~~))) (iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. (((~~(2) The PEBB program will change health plan enrollment as follows if the~~))) If that day is the first of the month, the change in health plan begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the public employees benefits board (PEBB) annual open enrollment.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to ((~~select~~)) elect a new health plan ((~~as required under subsection (1) of this section:~~

~~(a) Employees who fail to select a new health plan~~)) within the required time period as required in (a) or (b) of this subsection will be enrolled in a ((~~successor plan if one is available or an existing~~)) health plan designated by the director or designee.

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

~~(3) Any~~)) (2) A subscriber ((~~enrolled in a~~)) must elect a new health plan ((~~as described in subsection (2) of this section may not change~~)) when their previously selected health ((~~plans except as allowed in WAC 182-08-198~~)) plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

(a) The required forms electing a new health plan must be received no later than sixty days after the date their previously selected health plan becomes unavailable.

(b) An employee must submit the required forms to their employing agency electing their new health plan.

(c) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(d) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(e) A subscriber who is enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA), who fails to elect a new health plan within the required time period as required in this subsection, will not be eligible to receive contributions to the HSA. A subscriber will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(3) A subscriber enrolled in a health plan as described in subsection (1)(c) or (2) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

(a) An employee must complete the required forms indicating their enrollment elections, including an election to waive PEBB medical ((~~if~~)) provided the employee is eligible to waive PEBB medical and elects to waive ((~~PEBB medical~~)) as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency. ((~~Forms~~)) Their employing agency must ((~~be received by their employing agency~~)) receive the forms no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

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

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

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

(b) If a newly eligible employee's employing agency, or the authority's contracted vendor in the case of life insurance and AD&D insurance, does not receive the employee's required forms indicating medical, dental, life insurance, AD&D insurance, and LTD insurance elections, and the employee's tobacco use status attestation within thirty-one days of the employee becoming eligible, their enrollment will be as follows for those elections not received within thirty-one days:

(i) Uniform Medical Plan Classic;

(ii) Uniform Dental Plan;

(iii) Basic life insurance;

(iv) Basic AD&D insurance;

(v) Basic long-term disability insurance;

((~~(v)~~)) (vi) Dependents will not be enrolled; and

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

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

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

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

(i) An employee who self-paid for ((~~optional~~)) supplemental life ((~~PEBB~~)) insurance or supplemental AD&D coverage after losing eligibility will have that level of coverage reinstated without evidence of insurability effective the first day of the month in which the employee is in pay status eight or more hours;

(ii) An employee who was eligible to continue ((~~optional~~)) supplemental life or supplemental AD&D but discontinued that PEBB insurance coverage must submit evidence of insurability to the contracted vendor if they choose to reenroll when they regain eligibility for the employer contribution;

(iii) An employee who was eligible to continue ((~~optional~~)) supplemental LTD insurance but discontinued that PEBB insurance coverage must submit evidence of insurability for ((~~optional~~)) supplemental LTD insurance to the contracted vendor when they regain eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return a form indicating ((~~optional~~)) supplemental LTD insurance elections. Their ((~~optional~~)) supplemental LTD insurance will be automatically reinstated effective the first day of the month they are in pay status eight or more hours:

(i) The employee continued to self-pay for their ((~~optional~~)) supplemental LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue ((~~optional~~)) supplemental LTD insurance after losing eligibility for the employer contribution.

(c) If an employee's employing agency, or contracted vendor accepting forms directly, does not receive the required forms within thirty-one days of the employee regaining eligibility, ((~~medical, dental, life insurance, tobacco use surcharge, and LTD~~)) the employee's enrollment in PEBB insurance ((~~enrollment~~)) coverage will be as described in subsection (1)(b)(i) through (iv) and (vi) of this section, except as described in (b) of this subsection.

(d) If an employee is eligible to participate in the ((~~state's~~)) salary reduction plan (see WAC 182-12-116) the employee may enroll in the ((~~state's~~)) medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these ((~~optional~~)) supplemental PEBB benefits, the employee must return the required form to the contracted vendor or their state agency. The contracted vendor or employee's state agency must receive the form no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the ((~~state's~~)) salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is thirty days or less and within the current plan year. The employee must notify their new state agency of the transfer by providing the new state agency's personnel, payroll, or benefits office the required form no later than thirty-one days after the employee's first day of work with the new state agency.

(5) An employee's PEBB insurance coverage elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB insurance coverage for one month or more. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. PEBB insurance coverage elections also remain the same when an employee has a break in employment that does not interrupt their employer contribution toward PEBB insurance coverage.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

(1) **During the annual open enrollment:** A subscriber((~~s~~)) may change health plans during the public employees benefits board (PEBB) annual open enrollment period. ((~~The~~)) A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. ((~~All~~)) Any other subscriber((~~s~~)) submits the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber((~~s~~)) may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits. The change in enrollment must be allowable under Internal Revenue Code (((~~IRC~~))) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the

subscriber, the subscriber's dependent, or both. To make a health plan change, ((~~the~~)) a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to their employing agency. ((~~All~~)) Any other subscriber((~~s~~)) submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber((~~s~~)) must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, the new health plan coverage will begin the first day of the month following the date the medicare advantage plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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

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

(d) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

((**~~Exception:~~**)) **Note:** ((~~For the purposes of special open enrollment~~)) As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;

Exception: A dental plan is considered available if a provider is located within fifty miles of the subscriber's new residence.

(f) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

(i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196((~~(1)~~)) (2). A subscriber has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

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

(k) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent ((~~for a specific condition or ongoing course of treatment. The~~)). A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy ((~~for up to ninety days or until medically stable; or~~

~~(ii) Transplant within the last twelve months; or~~

~~(iii) Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or~~));

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period ((~~of up to eight weeks~~)); or

(v) ((~~Third trimester of~~)) Treatment for a high-risk pregnancy.

(3) If the employee is having premiums taken from payroll on a pretax basis, a health plan change will not be

approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-199 When may an employee enroll, or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)? An employee who is eligible to participate in the ((~~state's~~)) salary reduction plan as described in WAC 182-12-116 may enroll, or revoke their election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114((~~,~~)) and enrolling as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or opt out of participation under the ((~~state's~~)) premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment by submitting the required forms to their employing agency or applicable contracted vendor as instructed. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

Note: Employees enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. Employees who elect both will only be enrolled in the CDHP with a HSA.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the ((~~state's~~)) premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form to their employing agency. The employing agency must receive the required form and evidence of the event that created the special open enrollment no later than sixty days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** An employee may enroll or revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the ((~~subscriber~~)) employee;

• Birth, adoption, or when the ((~~subscriber~~)) employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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

• Employee has a change in marital status;

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

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

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

• An eligible dependent dies.

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

(iv) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

((~~**Exception:**~~)) ((~~For the purposes of special open enrollment~~)) As used in (a)(v) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

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

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

(viii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(ix) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

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

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

(xiv) Employee or an employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the employee or the employee's dependent ((~~for a specific condition or ongoing course of treatment~~)). The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

• Active cancer treatment such as chemotherapy or radiation therapy ((~~for up to ninety days or until medically stable; or~~

~~• Transplant within the last twelve months; or~~

~~• Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or~~));

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period ((~~of up to eight weeks~~)); or

• ((~~Third trimester of~~)) Treatment for a high-risk pregnancy.

(xv) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

If the employee is having premiums taken from payroll on a pretax basis, a plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

(b) **Medical ((~~flexible spending arrangement (~~))FSA((~~)~~)).** An employee may enroll or revoke their election and make a new election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the ((~~subscriber~~)) employee;

• Birth, adoption, or when the ((~~subscriber~~)) employee has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

• Employee has a change in marital status;

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

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

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

• An eligible dependent dies.

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

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the medical FSA;

(v) A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

(vii) Employee or an employee's dependent becomes entitled to coverage under medicare.

(c) **((~~Dependent care assistance program (~~))DCAP((~~)~~)).** An employee may enroll or revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership if the domestic partner qualifies as a tax dependent of the ((~~subscriber~~)) employee;

• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

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

(iv) Employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b)(1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in IRC 26 U.S.C. Sec. 152.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment or for faculty employed by more than one institution of higher education? Employing agencies responsible for paying the employer contribution:

(1) **For eligible employees changing agencies:** When an eligible employee's employment relationship terminates with an employing agency at any time during the month for which a premium contribution is due and that employee transfers to another agency, the ((~~losing~~)) agency losing the employee is responsible for the payment of the employer contribution for ((~~that~~)) the employee for that month. The receiving agency is liable for any employer contribution for the eligible employee beginning the first day of the month following the transfer.

(2) **For eligible faculty employed by more than one institution of higher education:**

(a) When a faculty is eligible for the employer contribution during an anticipated work period (quarter, semester or instructional year), under WAC 182-12-131(3), one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions during the anticipated work period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to the health care authority (HCA).

(b) When a faculty is eligible for the employer contribution during the summer or off-quarter/semester, under WAC 182-12-131 (3)(c), one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions throughout the instructional year or equivalent nine-month period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

(c) When a faculty is eligible through two-year averaging under WAC 182-12-131 (3)(d) for the employer contribution, one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes to coverage based on its percentage of the employee's total work at all institutions throughout the preceding two academic years. This division of the employer contribution begins the summer quarter or semester following the second academic year and continues through that academic year or until eligibility under two-year averaging ceases.

Note: "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters, in that order.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-08-235 Employer group ((~~and charter school~~)) application process. This section applies to employer groups as defined in WAC 182-08-015 ((~~and to charter schools~~)). An employer group ((~~or charter school~~)) may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA).

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

Employer groups ((~~and charter schools~~)) with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups ((~~and charter schools~~)) must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) ((~~School districts,~~)) Educational service districts((~~, and charter schools~~)) applying for its nonrepresented employees are required to provide the documents described in subsections (2)(a) through (c) of this section;

Exception: ((~~School districts and~~)) Educational service districts required by the superintendent of public instruction to purchase PEBB insurance coverage provided by the authority are required to submit documents and information described in subsection (2)(a)(iii), (b), and (c) of this section.

(b) Counties, municipalities, political subdivisions, and tribal governments with fewer than five thousand employees are required to provide the documents and information described in subsection (2)(a) through (f) of this section;

(c) Counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section; and

(d) All employee organizations representing state civil services employees and the Washington health benefit exchange, regardless of the number of employees, will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section.

(2) Documents and information required with application:

(a) A letter of application that includes the information described in (a)(i) through (iv) of this subsection:

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

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

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

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

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

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

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

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

(ii) Age;

(iii) Gender;

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

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

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

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

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

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

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

• A letter from their carrier indicating they will not or cannot provide claims data.

• Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.

• Current premiums for the health plan.

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

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

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

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

(iii) Executive summary of benefits;

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

(v) Summary of historical plan costs.

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

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

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-245 Employer group ((~~and charter school~~)) participation requirements. This section applies to an employer group as defined in WAC 182-08-015 ((~~or a charter school~~)) that is approved to purchase insurance for its employees through a contract with the health care authority (HCA).

(1) Prior to enrollment of employees in public employees benefits board (PEBB) insurance coverage, the employer group ((~~or charter school~~)) must:

(a) Remit to the authority the required start-up fee in the amount publicized by the PEBB program;

(b) Sign a contract with the authority;

(c) Determine employee and dependent eligibility and terms of enrollment for PEBB insurance coverage by the criteria outlined in this chapter and chapter 182-12 WAC unless otherwise approved by the authority in the employer group's ((~~or charter school's~~)) contract with the authority;

(d) Determine eligibility in order to ensure the PEBB program's continued status as a governmental plan under Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. This means the employer group ((~~or charter school~~)) may only consider employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities, whether or not those activities qualify as essential governmental functions to be eligible; and

(e) Ensure PEBB insurance coverage is the only employer-sponsored coverage available to groups of employees eligible for PEBB insurance coverage under the contract.

(2) Pay premiums under its contract with the authority based on the following premium structure:

(a) The premium rate structure for ((~~school districts,~~)) educational service districts((~~, and charter schools~~)) purchasing PEBB insurance coverage for nonrepresented employees will be a composite rate equal to the rate charged to state agencies plus an amount equal to the employee premium based on health plan election and family enrollment. ((~~School districts and~~)) Educational service districts must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their nonrepresented employees and include the funds in their payment to the authority.

Exception: The authority will allow educational service districts that enrolled prior to September 1, 2002, to continue participation based on a tiered rate structure. The authority may require the district to change to a composite rate structure with ninety days advance written notice.

(b) The premium rate structure for employer groups other than educational service districts ((~~and charter schools~~)) described in (a) of this subsection will be a tiered rate based on health plan election and family enrollment. Employer groups must collect an amount equal to the premium surcharges applied to an employee's account by the authority from their employees and include the funds in their payment to the authority.

Exception: The authority will allow employer groups that enrolled prior to January 1, 1996, to continue to participate based on a composite rate structure. The authority may require the employer group to change to a tiered rate structure with ninety days advance written notice.

(3) Counties, municipalities, political subdivisions, and tribal governments must pay the monthly employer group rate surcharge in the amount invoiced by the authority.

(4) If an employer group ((~~or charter school~~)) wants to make subsequent changes to the contract, the changes must be submitted to the authority for approval.

(5) The employer group ((~~or charter school~~)) must maintain participation in PEBB insurance coverage for at least one full year. An employer group ((~~or charter school~~)) may only end participation at the end of a plan year unless the authority approves a mid-year termination. To end participation, an employer group ((~~or charter school~~)) must provide written notice to the PEBB program at least sixty days before the requested termination date.

(6) Upon approval to purchase insurance through a contract with the authority, the employer group ((~~or charter school~~)) must provide a list of employees and dependents that are enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and the remaining number of months available to them based on their qualifying event. These employees and dependents may enroll in a PEBB health plan as COBRA subscribers for the remainder of the months available to them based on their qualifying event.

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

Exception: If an employer group, other than ((~~a school district or~~)) an educational service district, ends participation, retired and disabled employees who began participation before September 15, 1991, are eligible to continue enrollment in PEBB insurance coverage if the employee continues to meet the procedural and eligibility requirements of WAC 182-12-171. Employees who enrolled after September 15, 1991, who are enrolled in PEBB retiree insurance coverage cease to be eligible under WAC 182-12-171, but may continue health plan enrollment under COBRA (see WAC 182-12-146).

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-109 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agencies, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

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

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

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

"Benefits-eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).

"Blind vendor" means a "licensee" as defined in RCW 74.18.200.

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

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

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of health plan coverage available to enrollees ((~~after a qualifying event occurs as administered~~)) under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or ((~~PEBB insurance coverage extended by~~)) the public employees benefits ((~~board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270~~)) board's policies.

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

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

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

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

"Dependent care assistance program" or "DCAP" means a benefit plan whereby ((~~state and public~~)) employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Effective date of enrollment" means the first date when an enrollee is entitled to receive covered benefits.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization((~~, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization~~)); (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); ((~~and~~)) (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of

higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

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

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

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

"Employer contribution" means the funding amount paid to the ((~~authority~~)) HCA by a state agency((~~,~~)) or employer group((~~, or charter school~~)) for its eligible employees as described under WAC 182-12-114 and 182-12-131.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, ((~~school districts, educational service districts, and~~)) employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

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

"Employing agency" for the public employees benefits board means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, ((~~school district, educational service district,~~)) or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

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

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

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

"Federal retiree medical plan" means the Federal Employees Health Benefits program (FEHB) or TRICARE plans which are not employer-based group medical.

"Forms" or "form" means both paper forms and forms completed electronically.

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

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

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

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

"Long-term disability insurance" or "LTD insurance" ((~~includes~~)) means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee((~~s on an optional basis~~)).

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state ((~~and public~~)) employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Pay status" means all hours for which an employee receives pay.

"PEBB" means the public employees benefits board.

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

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

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

182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby ((~~state and~~)) public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

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

"Public employee" has the same meaning as employee.

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

"Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (((~~DCAP~~))), medical flexible spending arrangement (((~~FSA~~))), or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"School employee" includes:

(a) Through December 31, 2023, all employees of school districts and charter schools established under chapter 28A.710 RCW, and represented employees of educational service districts. For the exclusive purpose of eligibility for PEBB retiree insurance coverage, the term "school employee" also includes nonrepresented employees of an educational service district; and

(b) Effective January 1, 2024, all employees of school districts, educational service districts, and charter schools established under chapter 28A.710 RCW.

"SEBB" means school employees benefits board established in RCW 41.05.740.

"SEBB insurance coverage" means any health plan, life insurance, accidental death and dismemberment insurance, or long-term disability insurance administered as a SEBB benefit.

"SEBB organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees benefits board.

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

"Seasonal employee" means ((~~an~~)) a state employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

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

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government ((~~and all personnel thereof~~)). It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, ((~~or charter school~~)) is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee((~~s~~)).

"Supplemental coverage" means any life insurance, accidental death and dismemberment (AD&D) insurance coverage, or long-term disability coverage purchased by the employee in addition to the coverage provided by the employing agency.

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

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

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

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

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

WAC 182-12-111 Which entities and individuals are eligible for public employees benefits board (PEBB) benefits? The following entities and individuals shall be eligible for public employees benefits board (PEBB) benefits subject to the terms and conditions set forth below:

(1) **State agencies.** State agencies, as defined in WAC 182-12-109, are required to participate in all PEBB benefits. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

(2) **Employer groups.** Employer groups may apply to participate in PEBB insurance coverage for groups of employees described in (a)(i) of this subsection and for members of the group's governing authority as described in (a)(i), (ii), and (iii) of this subsection at the option of each employer group:

(a) All eligible employees of the entity must transfer as a unit with the following exceptions:

(i) Bargaining units may elect to participate separately from the whole group;

(ii) Nonrepresented employees may elect to participate separately from the whole group provided all nonrepresented employees join as a group; and

(iii) Members of the employer group's governing authority may participate as described in the employer group's governing statutes and RCW 41.04.205.

(b) Employer groups must apply through the process described in WAC 182-08-235. Applications from employees of employee organizations representing state civil service employees, the Washington health benefit exchange, and employer groups with five thousand or more employees, except for ((~~school districts and~~)) educational service districts are subject to review and approval by the health care authority (HCA) based on the employer group evaluation criteria described in WAC 182-08-240.

(c) Employer groups ((~~and charter schools~~)) participate through a contract with the authority as described in WAC 182-08-245.

(3) **((~~School districts,~~)) Washington state educational service districts((~~, and charter schools~~)).** In addition to subsection (2) of this section, the following applies to ((~~school districts,~~)) Washington state educational service districts((~~, and charter schools~~)) enrolling in PEBB insurance coverage for its nonrepresented employees until December 31, 2023:

(a) The HCA will collect an amount equal to the composite rate charged to state agencies, plus an amount equal to the employee premium by health plan and family size and an amount equal to any applicable premium surcharge as would be charged to state employees for each participating ((~~school district,~~)) educational service district((~~, or charter school~~)).

(b) The HCA may collect these amounts in accordance with the district fiscal year, as described in RCW 28A.505.-030.

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

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

(b) Employees of the Washington health benefit exchange are subject to the same rules as employees of an employing agency in chapters 182-08, 182-12 and 182-16 WAC.

(5) **Eligible nonemployees.**

(a) Blind vendors actively operating a business enterprise program facility in the state of Washington and deemed eligible by the department of services for the blind (DSB) may voluntarily participate in PEBB medical. Dependents of blind vendors are eligible as described in WAC 182-12-260. Eligible blind vendors and their dependents may enroll during the following times:

(i) When newly eligible: The DSB will notify eligible blind vendors of their eligibility in advance of the date they are eligible for enrollment in PEBB medical.

To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than thirty-one days after the blind vendor becomes eligible for PEBB medical.

(ii) During the annual open enrollment: Blind vendors may enroll during the annual open enrollment. The required form must be received by the DSB before the end of the annual open enrollment. Enrollment will begin January 1st of the following year.

(iii) Following loss of other medical insurance coverage: Blind vendors may enroll following loss of other medical insurance coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA). To enroll, blind vendors must submit the required forms to the DSB. The forms must be received by the DSB no later than sixty days after the loss of other medical insurance coverage. In addition to the required forms, the DSB will require blind vendors to provide evidence of loss of other medical insurance coverage.

(iv) Blind vendors who cease to actively operate a facility become ineligible to participate in PEBB medical as described in (a) of this subsection. Enrollees who lose eligibility for coverage may continue enrollment in PEBB medical on a self-pay basis under COBRA coverage as described in WAC 182-12-146(5).

(v) Blind vendors are not eligible for PEBB retiree insurance coverage.

(b) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB health plans while enrolled in that program.

(c) School board members or students eligible to participate under RCW 28A.400.350 may participate in PEBB insurance coverage as long as they remain eligible under that section.

(6) **Individuals and entities not eligible as employees include:**

(a) Adult family home providers as defined in RCW 70.128.010;

(b) Unpaid volunteers;

(c) Patients of state hospitals;

(d) Inmates in work programs offered by the Washington state department of corrections as described in RCW 72.09.-100 or an equivalent program administered by a local government;

(e) Employees of the Washington state convention and trade center as provided in RCW 41.05.110;

(f) Students of institutions of higher education as determined by their institutions; and

(g) Any others not expressly defined as an employee.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

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

(2) All state agencies must determine employee eligibility for PEBB benefits and the employer contribution according to the criteria in WAC 182-12-114 and 182-12-131. State agencies must:

(a) Notify newly hired employees of PEBB program rules and guidance for eligibility and appeal rights;

(b) Provide written notice to faculty who are potentially eligible for benefits and employer contribution of their potential eligibility as described in WAC 182-12-114(3) and 182-12-131;

(c) Inform an employee in writing whether or not they are eligible for benefits upon employment. The written communication must include a description of any hours that are excluded in determining eligibility and information about the employee's right to appeal eligibility and enrollment decisions;

(d) Routinely monitor all employees' eligible work hours to establish eligibility and maintain the employer contribution toward PEBB ((~~insurance coverage~~)) benefits;

(e) Make eligibility determinations based on the criteria of the eligibility category that most closely describes the employee's work circumstances per the PEBB program's direction;

(f) Identify when a previously ineligible employee becomes eligible or a previously eligible employee loses eligibility; and

(g) Inform an employee in writing whether or not they are eligible for benefits and the employer contribution whenever there is a change in work patterns such that the employee's eligibility status changes. ((~~At the same time,~~)) Whenever this occurs, state agencies must inform the employee((~~s~~)) of the right to appeal eligibility and enrollment decisions.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-114 How do employees establish eligibility for public employees benefits board (PEBB) benefits? Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in subsections (1) through (5) of this section shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

Hours that are excluded in determining eligibility include standby hours and any temporary increases in work hours, of six months or less, caused by training or emergencies that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Employing agencies must request the public employees benefits board (PEBB) program's approval to include temporary training or emergency hours in determining eligibility.

For how the employer contribution toward PEBB insurance coverage is maintained after eligibility is established under this section, see WAC 182-12-131.

(1) Employees are eligible for PEBB benefits as follows, except as described in subsections (2) through (5) of this section:

(a) **Eligibility.** An employee is eligible if they are anticipated to work an average of at least eighty hours per month and are anticipated to work for at least eight hours in each month for more than six consecutive months.

(b) **Determining eligibility.**

(i) **Upon employment:** An employee is eligible from the date of employment if the employing agency anticipates the employee will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern:** If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern:** An employee who is determined to be ineligible, but later meets the eligibility criteria in (a) of this subsection, becomes eligible the first of the month following the six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees become eligible through stacking when they meet the requirements described in (a) of this subsection. They must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(2) **Seasonal employees,** as defined in WAC 182-12-109, are eligible as follows:

(a) **Eligibility.** A seasonal employee is eligible if they are anticipated to work an average of at least eighty hours per month and are anticipated to work for at least eight hours in each month of at least three consecutive months of the season.

(b) **Determining eligibility.**

(i) **Upon employment:** A seasonal employee is eligible from the date of employment if the employing agency anticipates that they will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern.** If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern.** An employee who is determined to be ineligible for benefits, but later works an average of at least eighty hours per month and works for at least eight hours in each month and works for more than six consecutive months, becomes eligible the first of the month following a six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees become eligible through stacking when they meet the requirements described in (a) of this subsection. They must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position or job with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, basic AD&D insurance, and basic LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(3) **Faculty** are eligible as follows:

(a) **Determining eligibility.** "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees is governed by RCW 28B.50.489.

(i) **Upon employment:** Faculty who the employing agency anticipates will work half-time or more for the entire instructional year, or equivalent nine-month period, are eligible from the date of employment.

(ii) **For faculty hired on quarter/semester to quarter/semester basis:** Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which they are anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.

(iii) **Upon revision of anticipated work pattern:** Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria as described in (a)(i) or (ii) of this subsection become eligible when the revision is made.

(b) **Stacking.** Faculty may establish eligibility and maintain the employer contribution toward PEBB insurance coverage by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under this section or maintain eligibility as described in WAC 182-12-131(3). A faculty becomes eligible through stacking when they meet the requirements as described in (a) of this subsection. When a faculty works for more than one institution of higher education, the faculty must notify their employing agencies that they work at more than one institution and may be eligible through stacking.

(c) **When PEBB insurance coverage begins.**

(i) Medical, dental, basic life insurance, basic AD&D insurance, and basic LTD insurance begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical, dental, basic life insurance, basic AD&D insurance, and basic LTD insurance begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, then PEBB insurance coverage begins at the beginning of the second consecutive quarter/semester.

(4) **Elected and full-time appointed officials of the legislative and executive branches of state government** are eligible as follows:

(a) **Eligibility.** A legislator is eligible for PEBB benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

(b) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, basic AD&D insurance, and basic LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(5) **Justices and judges** are eligible as follows:

(a) **Eligibility.** A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

(b) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, basic AD&D insurance, and basic LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

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

WAC 182-12-116 Who is eligible to participate in the ((~~state's~~)) salary reduction plan? (1) Employees of state agencies are eligible to participate in the state's salary reduction plan provided they are eligible for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 and they elect to participate within the time frames described in WAC 182-08-197, 182-08-187, or 182-08-199.

(2) Employees of employer groups, as defined in WAC 182-12-109, ((~~and charter schools~~)) are not eligible to participate in the state's salary reduction plan.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-123 Is dual enrollment in public employees benefits board (PEBB) prohibited? Public employees benefits board (PEBB) health plan coverage is limited to a single enrollment per individual.

(1) An individual who has more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") is limited to one enrollment.

(2) An eligible employee may waive PEBB medical and enroll as a dependent under the health plan of their spouse, state registered domestic partner, or parent as described in WAC 182-12-128.

(3) A dependent enrolled in a PEBB health plan who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or (3). This includes making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128.

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent. If the employee's spouse, state registered domestic partner, or parent does not remove the employee (who is enrolled as a dependent) from their subscriber account, the PEBB program will terminate the employee's enrollment as a dependent the last day of the month before the employee's ((~~employer-paid coverage~~)) enrollment in PEBB benefits begins as described in WAC 182-12-114.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee may be dual-enrolled in PEBB coverage for one month. This exception is only allowed for the first month the dependent is enrolled as an employee, and only if the dependent becomes enrolled as an employee on the first working day of a month that is not the first day of the month.

(b) If the employee elects to waive their enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent.

(4) A child who is eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(5) When an employee is eligible for the employer contribution towards PEBB insurance coverage due to employment in more than one PEBB-participating employing agency the following provisions apply:

(a) The employee must choose to enroll under only one employing agency.

Exception: Faculty who stack to establish or maintain eligibility as described in WAC 182-12-114(3) with two or more state institutions of higher education will be enrolled under the employing agency responsible to pay the employer contribution according to WAC 182-08-200(2).

(b) If the employee loses eligibility under the employing agency, they ((~~may choose to enroll as described in (a) of this subsection, the employee~~)) must notify their other employing agency no later than sixty days from the date PEBB coverage ends through the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's PEBB insurance coverage elections remain the same when an employee transfers their enrollment ((~~from enrollment~~)) under one employing agency to another employing agency without a break in PEBB insurance coverage for one month or more, as described in (b) of this subsection.

(6) A retiree who defers enrollment in a PEBB health plan as described in WAC 182-12-200 by enrolling as an eligible dependent in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educa-

tional service district, or ((~~a Washington state charter school~~)) SEBB and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC 182-12-200 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may they enroll in PEBB medical after having waived enrollment? An employee may waive enrollment in public employees benefits board (PEBB) medical if they are enrolled in other employer-based group medical, a TRICARE plan, or medicare as described in subsection (1)(a) through (c) of this section. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits. An employee who waives enrollment in PEBB medical must enroll in dental, basic life insurance, basic accidental death and dismemberment insurance, and basic long-term disability (LTD) insurance (unless the employing agency does not participate in these PEBB insurance coverages).

(1) To waive enrollment in PEBB medical, the employee must submit the required form to their employing agency at one of the following times:

(a) **When the employee becomes eligible:** An employee ((~~enrolled in other employer-based group medical, a TRICARE plan, or medicare~~)) may waive PEBB medical when they become eligible for PEBB benefits. The employee must indicate their election to waive enrollment in PEBB medical on the required form and submit the form to their employing agency. The employing agency must receive the form no later than thirty-one days after the date the employee becomes eligible for benefits (see WAC 182-08-197). PEBB medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** An employee may waive PEBB medical during the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will be waived beginning January 1st of the following year.

(c) **During a special open enrollment:** An employee may waive PEBB medical during a special open enrollment as described in subsection (4) of this section.

The employee must submit the required form to their employing agency. The employing agency must receive the form no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will be waived the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, PEBB medical will be waived the last day of the previous month. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will be waived the last day of the previous month.

(2) If an employee waives PEBB medical, the ((~~employee's eligible~~)) employee may not enroll dependents ((~~may not be enrolled~~)) in PEBB medical.

(3) Once PEBB medical is waived, the employee is only allowed to enroll in PEBB medical at the following times:

(a) During the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows an employee to revoke their election and make a new election outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

The employee must submit the required form to their employing agency. The employing agency must receive the form no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will begin ((~~as follows:~~

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

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

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

~~(iv) For the spouse or state registered domestic partner of an employee, PEBB medical will begin the first day of the month in which the event occurs~~)) (see WAC 182-12-262 for the PEBB medical effective date of a newly born child, newly adopted child, spouse, or state registered domestic partner).

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open enrollment. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both.

(a) Employee acquires a new dependent due to:

(i) Marriage or registering ((~~for~~)) a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Employee or an employee's dependent loses other coverage under a group health plan or through health insur-

ance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Employee has a change in employment status that affects the employee's eligibility for their employer contribution toward their employer-based group medical;

(d) The employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group medical;

((~~**Exception:**~~)) **Note:** ((~~For the purposes of special open enrollment~~)) As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

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

(f) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(g) A court order requires the employee or any other individual to provide a health plan for an eligible dependent of the ((~~subscriber~~)) employee (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

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

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) insurance coverage? The employer contribution toward public employees benefits board (PEBB) insurance coverage begins on the day that PEBB benefits begin as described in WAC 182-12-114. This section describes under what circumstances employees maintain eligibility for the employer contribution toward PEBB insurance coverage.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, employees who have established eligibility for benefits as described in WAC 182-12-114 are eligible for the employer contribution each month in which they are in pay status eight or more hours per month.

(2) **Maintaining the employer contribution - Benefits-eligible seasonal employees.**

(a) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of less than nine months are eligible for the employer contribution in any month of the season in which they are in pay status eight or more hours during that month. The employer contribution toward PEBB insurance coverage for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of nine months or more are eligible for the employer contribution:

(i) In any month of the season in which they are in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked, but the eligibility may not exceed a total of twelve consecutive calendar months for the combined season and off season.

(3) **Maintaining the employer contribution - Eligible faculty.**

(a) Benefits-eligible faculty anticipated to work half time or more the entire instructional year or equivalent nine-month period (eligible as described in WAC 182-12-114 (3)(a)(i)) are eligible for the employer contribution each month of the instructional year, except as described in subsection (7) of this section.

(b) Benefits-eligible faculty who are hired on a quarter/semester to quarter/semester basis (eligible as described in WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which employees work half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who work an average of half-time or more throughout the entire instructional year or equivalent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester PEBB insurance coverage.

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester PEBB insurance coverage ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment. If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB insurance coverage ends the last day of the month for which employee premiums were deducted.

(d) Two-year averaging: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who worked an average of half-time or more in each of the two preceding academic years are potentially eligible to

receive uninterrupted employer contribution toward PEBB insurance coverage. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of their potential eligibility to their employing agency or agencies within the deadlines established by the employing agency or agencies. Faculty continue to receive uninterrupted employer contribution for each academic year in which they:

(i) Are employed on a quarter/semester to quarter/semester basis and work at least two quarters or two semesters; and

(ii) Have an average workload of half-time or more for three quarters or two semesters.

Eligibility for the employer contribution under two-year averaging ceases immediately if the eligibility criteria is not met or if the eligibility criteria becomes impossible to meet.

(e) Faculty who lose eligibility for the employer contribution: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins.

(4) **Maintaining the employer contribution - Employees on leave and under the special circumstances listed below.**

(a) Employees who are on approved leave under the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program continue to receive the employer contribution as long as they are approved under the act.

(b) Unless otherwise indicated in this section, employees in the following circumstances receive the employer contribution only for the months they are in pay status eight hours or more:

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

(iii) Employees receiving time-loss benefits under workers' compensation;

(iv) Employees called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or

(v) Employees applying for disability retirement.

(5) **Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff** maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-129.

(6) **Employees who are in pay status less than eight hours in a month.** Unless otherwise indicated in this section, when there is a month in which employees are not in pay status for at least eight hours, employees:

(a) Lose eligibility for the employer contribution for that month; and

(b) Must reestablish eligibility for PEBB benefits as described in WAC 182-12-114 in order to be eligible for the employer contribution again.

(7) **The employer contribution toward PEBB insurance coverage ends** in any one of these circumstances for all employees:

(a) When employees fail to maintain eligibility for the employer contribution as indicated in the criteria in subsection (1) through (6) of this section.

(b) When the employment relationship is terminated. As long as the employing agency has no anticipation that the employee will be rehired, the employment relationship is terminated:

(i) On the date specified in an employee's letter of resignation; or

(ii) On the date specified in any contract or hire letter or on the effective date of an employer-initiated termination notice.

(c) When employees move to a position that is not anticipated to be eligible for PEBB benefits as described in WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB benefits cease for employees and their enrolled dependents the last day of the month in which employees are eligible for the employer contribution under this section.

Exception: If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB insurance coverage ends the last day of the month for which employee premiums were deducted.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward PEBB insurance coverage, employees have options for providing continuation coverage for themselves and their dependents by self-paying the premium and applicable premium surcharges set by the health care authority (HCA). These options are available as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff? Employees who have established eligibility for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

(1) Employees who are no longer eligible for the employer contribution toward PEBB ((~~insurance coverage~~)) benefits due to an event described in (b)(i) through (vi) of this subsection may continue PEBB ((~~insurance coverage~~)) benefits by self-paying the premium and applicable premium surcharges set by the health care authority (HCA) from the date eligibility for the employer contribution is lost:

(a) Employees may continue any combination of medical, dental, ((~~and~~)) life insurance, and accidental death and

dismemberment (AD&D) insurance; however, only employees on approved educational leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue either basic or both basic and ((~~optional~~)) supplemental long-term disability (LTD) insurance.

(b) Employees in the following circumstances who lose their eligibility for the employer contribution toward PEBB benefits qualify to continue coverage under this subsection:

(i) Employees who are on authorized leave without pay;

(ii) Employees who are on approved educational leave;

(iii) Employees who are receiving time-loss benefits under workers' compensation;

(iv) Employees who are called to active duty in the uniformed services as defined under USERRA;

(v) Employees whose employment ends due to a layoff as defined in WAC 182-12-109; ((~~or~~)) and

(vi) Employees who are applying for disability retirement.

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

(d) Employees may self-pay for a maximum of twenty-nine months. The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due ((~~to the HCA~~)) no later than forty-five days after the election period ends as described in (c) of this subsection.

Premiums and applicable premium surcharges associated with continuing PEBB medical, must be made to the HCA as well as premiums associated with continuing PEBB dental or LTD insurance coverage. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor. Following the employee's first premium payment, the employee must pay the premium amounts for PEBB insurance coverage and applicable premium surcharges as premiums become due((~~.~~)); and

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

(2) The number of months that employees self-pay the premium while eligible as described in subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees who are no longer eligible for continuation coverage as described in subsection (1) of this section but who have not used the maximum number of months allowed under COBRA coverage may continue medical, dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharges as described in WAC 182-12-146.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA) or the paid family and medical leave program? (1) An employee on approved leave under the federal Family and Medical Leave Act (FMLA) or the family and medical leave insurance program under chapter 50A.04 RCW (paid family and medical leave program) may continue to receive the employer contribution toward public employees benefits board (PEBB) insurance coverage in accordance with the federal FMLA or RCW 50A.04.245. The employee may also continue current ((~~optional~~)) supplemental life, supplemental accidental death and dismemberment (AD&D), and ((~~optional~~)) supplemental long-term disability (((~~LTD~~))) insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave. The employment security department is responsible for determining if the employee is eligible for leave under the paid family and medical leave program.

(2) If an employee's monthly premium or applicable premium surcharges remain((~~s~~)) unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges ((~~was~~)) were paid.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-141 If an employee reverts from an eligible position, what happens to their public employees benefits board (PEBB) insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward public employees benefits board (PEBB) insurance coverage under this chapter, they may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) for up to eighteen months under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1):

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

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with

continuing life insurance and accidental death and dismemberment insurance coverage must be made to the contracted vendor;

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

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

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward PEBB insurance coverage under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharges set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical, dental, ((~~and~~)) life insurance, and accidental death and dismemberment (AD&D) insurance by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility:

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

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor;

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

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

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental, ((~~and~~)) life insurance, and AD&D insurance by self-paying the premium and applicable premium surcharges set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility:

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

(b) The employee's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance and AD&D insurance coverage must be made to the contracted vendor;

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

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

(3) **COBRA.** An employee who is no longer eligible for continuation coverage as described in subsections (1) and (2) of this section, but who has not used the maximum number of months allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), may continue medical, dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharges set by the HCA under COBRA as described in WAC 182-12-146. The number of months that a faculty or seasonal employee self-pays premiums under the criteria in subsection (1) or (2) of this section will count toward the total months of continuation coverage allowed under COBRA.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-146 When is an enrollee eligible to continue public ((~~employee's~~)) employees benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) ((~~An enrollee may continue public employee's benefits board (PEBB) health plan coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) by self-paying the premium and applicable premium surcharge set by the health care authority (HCA):~~

~~Note:~~ ~~Based on RCW 26.60.015 and public employee benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, an employee's state registered domestic partner and the state registered domestic partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.~~

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

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

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

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

~~(2) An employee or an employee's dependent who loses eligibility for the employer contribution toward PEBB insurance coverage and who qualifies for continuation coverage under COBRA may continue medical, dental, or both.~~

~~(3)~~)) An employee or an employee's dependent who loses eligibility for the employer contribution toward public employees benefits board (PEBB) benefits and who qualifies for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) may continue coverage for medical, dental, or both.

(2) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148 but who has not used the maximum number of months allowed under COBRA may continue medical, dental, or both for the remaining difference in months.

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

(((~~(5) A retired employee,~~))) (4) A retiree or a dependent of a ((~~retired employee~~)) retiree, who is no longer eligible ((~~to continue coverage~~)) as described in WAC 182-12-171, 182-12-180, or 182-12-260 may continue medical, dental, or both.

(((~~(6)~~))) (5) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in PEBB medical for the maximum number of months allowed under COBRA as described in this section.

A blind vendor is not eligible for PEBB retiree insurance coverage.

(6) An enrollee may continue PEBB health plan coverage under COBRA by self-paying the premium and applicable premium surcharges set by the health care authority (HCA):

Note: Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, a subscriber's state registered domestic partner and the state registered domestic partner's children may continue PEBB benefits on the same terms and conditions as spouses and other eligible dependents under COBRA.

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

(b) The first premium payment under COBRA coverage and applicable premium surcharges are due to the HCA no later than forty-five days after the election period ends as described in (a) of this subsection. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);

(c) COBRA continuation coverage enrollees who voluntarily terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility as described in WAC 182-12-114. Those who request to terminate their COBRA coverage must do so in writing. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request or on the last day of the month specified in the COBRA enrollee's termination request, whichever is later. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month;

(d) An employee enrolled in a medical flexible spending arrangement (FSA) and the employee's dependents will have an opportunity to continue making contributions to their medical FSA by electing COBRA if on the date of the qualifying event, as described under 42 U.S.C. Sec. 300bb-3, the employee's medical FSA has a greater amount in remaining benefits than remaining contribution payments for the current year. The election must be received by the contracted vendor no later than sixty days from the date the PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later. The first premium payment under COBRA coverage is due to the contracted vendor no later than forty-five days after the election period ends as described above.

(7) Medical and dental coverage under COBRA begin on the first day of the month following the day the COBRA enrollee loses eligibility for PEBB health plan coverage as described in WAC 182-12-131, 182-12-133, 182-12-141, 182-12-142, 182-12-148, 182-12-171, 182-12-180, 182-12-250, 182-12-260, or 182-12-265.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting hearing of a dismissal action before any of the following may continue their public employees benefits board (PEBB) insurance coverage by self-paying the premium and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, on the same terms as an employee who is granted leave as described in WAC 182-12-133:

(a) The personnel resources board;

(b) An arbitrator; or

(c) A grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) The employee must pay premium amounts and applicable premium surcharges associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharges remain((~~s~~)) unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c).

(3) If the dismissal is upheld, all PEBB insurance coverage will end at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is later, with the exception described in subsection (4) of this section.

(4) If the dismissal is upheld and the employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the employee may continue medical, dental, or both for the remaining months available under COBRA. See WAC 182-12-146 for information on COBRA. The number of months the employee self-paid premiums during the appeal will count toward the total number of months allowed under COBRA.

(5) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid PEBB insurance coverage retroactively, the employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

(a) When the employer contribution is reinstated, the HCA will refund to the employee any premiums and applicable premium surcharges the employee paid ((~~that may be provided for as a result of the reinstatement of the employer contribution only if the employee makes retroactive payment of any employee contribution amounts associated with the PEBB insurance coverage~~)). In the alternative, at the request of the employee, HCA may deduct the employee's contribution amount for PEBB insurance coverage from the refund of ((~~any~~)) premiums and applicable premium surcharges self-paid by the employee during the appeal period.

(b) All ((~~optional~~)) supplemental life, supplemental accidental death and dismemberment, and ((~~optional~~)) supplemental LTD insurance which was in force at the time of dismissal shall be reinstated retroactively only if the employee makes retroactive payment of premium for any such ((~~optional~~)) supplemental coverage which was not continued by self-payment during the appeal process. If the employee chooses not to pay the retroactive premium, evidence of insurability will be required to restore such ((~~optional~~)) supplemental coverage.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-171 When is a retiring employee or a retiring school employee eligible to enroll in public employees benefits board (PEBB) retiree insurance coverage? A retiring employee or a retiring school employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements as described in subsections (1), (2), and (3) of this section. An elected and full-time appointed official of the legislative and executive branch of state government is eligible as described in WAC 182-12-180.

(1) **Procedural requirements.** A retiring employee or a retiring school employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) through (d) of this subsection:

(a) To enroll in PEBB retiree insurance coverage, the required form must be received by the PEBB program no later than sixty days after the employee's or the school employee's employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the employee's or the school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends;

(b) The employee's or the school employee's first premium payment for PEBB retiree insurance coverage enrollment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in (a) of this subsection. Following the employee's or the school employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c); and

(c) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee;

Exception: If a retiring employee or a retiring school employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in a PEBB health plan, the employee or the school employee must meet substantive eligibility requirements in subsection (2) of this section and defer enrollment as described in WAC 182-12-200 or 182-12-205.

(2) **Substantive eligibility requirements.**

(a) An employee ((~~as defined in WAC 182-12-109~~)) who is eligible for PEBB benefits through an employing agency, or ((~~an~~)) a school employee who is ((~~enrolled in~~)) eligible for SEBB benefits through a SEBB organization or basic benefits through ((~~a Washington state school district,~~)) an educational service district as defined in RCW 28A.400.270((~~, or a charter school~~)) and ends public employment after becoming vested in a Washington state-sponsored retirement plan may enroll or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements.

To be eligible to continue enrollment or defer enrollment in PEBB insurance coverage as a retiree, the employee or the school employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's or school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) A retiring employee of a state agency must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage.

(c) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service;

(d) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (i) or (ii) of this subsection to be eligible to continue PEBB insurance coverage as a retiree, except for ((~~a school district,~~)) an educational service district((~~, or charter school~~)) employee who must meet the requirements as described in subsection (2)(e) of this section.

(i) A retiring employee who is eligible to retire under a retirement plan sponsored by an employer group or tribal government that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if they were a member of public employees retirement system Plan 1 or Plan 2 during their employment with that employer group or tribal government.

(ii) A retiring employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in subsection (2)(b)(i) and (ii) of this section.

(iii) A retired employee of an employer group, except a Washington state ((~~school district,~~)) educational service district, ((~~or charter school~~)) that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage if they enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(iv) A retired employee of a tribal government employer that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(e) A retiring school employee ((~~of a Washington state school district, Washington state educational service district, or a Washington state charter school~~)) must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring school employee who ends employment before October 1, 1993; or

(ii) A retiring school employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the school employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the school employee enrolled before 1995; or

(iii) A retiring school employee who is a member of a Plan 3 retirement system, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria; or

(iv) ((~~An~~)) A school employee who retired as of September 30, 1993, and began receiving a monthly retirement plan payment from a Washington state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) is eligible if they enrolled in a PEBB health plan no later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) A retiring employee or a retiring school employee and their enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare Parts A and B if the employee or the school employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is entitled to medicare does

not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(4) Washington state-sponsored retirement plans include:

(a) Higher education retirement plans;

(b) Law enforcement officers' and firefighters' retirement system;

(c) Public employees' retirement system;

(d) Public safety employees' retirement system;

(e) School employees' retirement system;

(f) State judges/judicial retirement system;

(g) Teachers' retirement system; and

(h) State patrol retirement system.

(i) The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered Washington state-sponsored retirement systems for Washington State University Extension for an employee covered under PEBB insurance coverage at the time of retirement.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

(a) A member of the state legislature;

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

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

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

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

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

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

(3) **Procedural requirements.** An official described in subsection (1) of this section or their survivor described in subsection (2) of this section must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a) through (d) of this subsection:

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

For a survivor to enroll in PEBB retiree insurance coverage, the required forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the date of the official's death or the first day of the month after the survivor's PEBB insurance coverage ends;

(b) The official's or survivor's first premium payment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the official's or survivor's election period ends as described in (a) of this subsection. Following the official's or survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c);

(c) If an official or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the official or survivor;

Exception: If an official or a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If an official or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

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

(4) If the official, an enrolled dependent, or their survivor is entitled to medicare or becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(5) An official described in subsection (1) of this section shall be included in the term "retiree" or "retiring employee" as used in chapters 182-08, 182-12, and 182-16 WAC.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-200 May a retiring employee, a retiring school employee, or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washing-~~

~~ton state charter~~)) school employees benefits board (SEBB) defer PEBB health plan enrollment under PEBB retiree insurance coverage? (1) A retiring employee or a retiring school employee may defer enrollment in a public employees benefits board (PEBB) health plan at retirement or after enrolling in PEBB retiree insurance coverage. Enrollment in a PEBB health plan may be deferred when they are enrolled as a dependent in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter school~~)) SEBB, including such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage. A retiring employee or a retiring school employee who defers enrollment at retirement must meet substantive eligibility requirements as described in WAC 182-12-171(2) or requirements as described in WAC 182-12-180(1).

(2) A retiree who defers enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental. A retiree who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents.

(3) A retiree who defers enrollment may later enroll in a PEBB health plan if they provide evidence of continuous enrollment in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter school~~)) SEBB, and submits the required form as described in (a) and (b) of this subsection:

(a) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(b) When enrollment in a health plan sponsored by PEBB, ((~~a Washington state school district,~~)) a Washington state educational service district, or ((~~a Washington state charter school~~)) SEBB ends, or such coverage under COBRA or continuation coverage ends. The required forms to enroll must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month following the date the other coverage ends. To continue in a deferred status, the retiree must defer enrollment as described in WAC 182-12-205.

(4) If a retiree elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical or PEBB dental plan as the retiree.

Exception: If a retiree selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiree selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-205 May a retiree or a survivor defer or voluntarily terminate public employees benefits board (PEBB) health plan enrollment under PEBB retiree insurance coverage? (1) The following individuals may defer enrollment in a public employees benefits board (PEBB) health plan:

(a) A retiring employee or a retiring school employee;

(b) A dependent becoming eligible as a survivor; or

(c) A retiree or a survivor enrolled in PEBB retiree insurance coverage.

(2) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents, except as described in subsection (3)(c) of this section.

(3) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan must maintain continuous enrollment in other medical as described in this section or WAC 182-12-200. A subscriber who defers enrollment in medical must defer enrollment in dental. A subscriber must be enrolled in medical to enroll in dental.

(a) Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in employer-based group medical as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

(b) Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.

(c) Beginning January 1, 2006, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter. Dependents may continue their PEBB health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(d) Beginning January 1, 2014, subscribers who are not eligible for Parts A and B of medicare may defer enrollment in a PEBB health plan when the subscriber is enrolled in exchange coverage.

(e) Beginning July 17, 2018, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled ((~~as a retiree or the dependent of a retiree~~)) in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

(4) To defer PEBB health plan enrollment, the required forms must be submitted to the PEBB program.

(a) For a retiring employee or a retiring school employee who meets the substantive eligibility requirements as described in WAC 182-12-171(2), enrollment will be deferred the first of the month following the date their employer-paid coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) For an official leaving public office who meets the requirements as described in WAC 182-12-180(1), enrollment will be deferred the first of the month following the date the official leaves public office. The forms must be received by the PEBB program no later than sixty days after the official leaves public office.

(c) For an employee or a school employee determined to be retroactively eligible for disability retirement who meets

the requirements as described in WAC 182-12-211 (1)(a) through (c), enrollment will be deferred as described in WAC 182-12-211 (2) or (3). The forms and formal determination letter must be received by the PEBB program no later than sixty days after the date on the determination letter.

(d) For an eligible survivor, the dependent must meet the requirements described below and the forms must be received by the PEBB program within the time described:

(i) For a survivor of an employee or a school employee who meets the requirements as described in WAC 182-12-265 (1) or (3), enrollment will be deferred the first of the month following the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage, ((~~school district coverage,~~)) educational service district coverage, or ((~~charter~~)) school employees benefits board (SEBB) insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage, ((~~school district coverage,~~)) educational service district coverage, or ((~~charter school~~)) SEBB insurance coverage ends.

(ii) For a survivor of an official who meets the requirements as described in WAC 182-12-180(2), enrollment will be deferred the first of the month following the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends.

(iii) For a survivor of a retiree who meets the requirements as described in WAC 182-12-265(2), enrollment will be deferred the first of the month following the date of the retiree's death. The forms must be received by the PEBB program no later than sixty days after the retiree's death.

(iv) For a survivor of an emergency service personnel killed in the line of duty who meets the requirements as described in WAC 182-12-250, enrollment will be deferred the first of the month following the later of one of the events described in WAC 182-12-250 (5)(a) through (d). The forms must be received by the PEBB program no later than one hundred eighty days after the later of one of the events described in WAC 182-12-250 (5)(a) through (d).

(e) For an enrolled retiree or survivor who submits the required forms to defer enrollment in a PEBB health plan, enrollment will be deferred effective the first of the month following the date the required forms are received by the PEBB program. If the forms are received on the first day of the month, enrollment will be deferred effective that day.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB health plan will be deferred effective the first of the month following the date the medicare advantage plan disenrollment form is received.

(5) A retiree who meets substantive eligibility requirements in WAC 182-12-171(2) and whose employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to have submitted the deferral form at that time, but must meet all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

(6) A subscriber described in subsection (1) of this section who defers enrollment while enrolled in qualifying coverage as described in subsection (3)(a) through (e) of this section may later enroll themselves and their dependents in a PEBB health plan by submitting the required forms as described below and evidence of continuous enrollment in one or more qualifying coverages as described in subsection (3)(a) through (e) of this section:

(a) A subscriber who defers enrollment while enrolled in employer-based group medical or such medical insurance continued under COBRA coverage or continuation coverage may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their employer-based group medical or such coverage under COBRA coverage or continuation coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after the employer-based group medical coverage, COBRA coverage, or continuation coverage ends.

(b) A subscriber who defers enrollment while enrolled as a retiree or dependent of a retiree in a federal retiree medical plan will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When the federal retiree medical plan coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

(c) A subscriber who defers enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their medicaid coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after

coverage ends. PEBB health plan coverage begins the first day of the month after the medicaid coverage ends; or

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree or survivor was also determined eligible under 42 U.S.C. § 1395w-114 and subsequently enrolled in a medicare Part D plan. Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends. The required forms must be received by the PEBB program no later than the last day of the calendar year in which the medicaid coverage ends.

(d) A subscriber who defers enrollment while enrolled in exchange coverage will have a one-time opportunity to enroll or reenroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When exchange coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

(e) A subscriber who defers enrollment while enrolled ((~~as a retiree or dependent of a retiree~~)) in CHAMPVA will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When CHAMPVA coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after CHAMPVA coverage ends.

(f) A subscriber who defers enrollment may enroll in a PEBB health plan if they receive formal notice that the authority has determined it is more cost-effective to enroll them or their eligible dependents in PEBB medical than a medical assistance program.

(g) If a subscriber elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the subscriber.

Exception: If a subscriber selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a subscriber selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(7) An enrolled retiree or a survivor who requests to voluntarily terminate their enrollment in a PEBB health plan must do so in writing. The written termination request must be received by the PEBB program. A retiree or a survivor who voluntarily terminates their enrollment in a PEBB health plan also terminates enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible. Enrollment in a PEBB health plan will terminate on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, enrollment in a PEBB health plan will terminate on the last day of the previous month.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB health plan will terminate on the last day of the month when the medicare advantage plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be terminated by the health care authority (HCA)? A retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage can be terminated by the health care authority (HCA) for the following reasons:

(1) Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB program;

(2) Knowingly providing false information;

(3) Failure to pay the monthly premium or applicable premium surcharges when due as described in WAC 182-08-180 (1)(c);

(4) Misconduct. If a retiree's PEBB insurance coverage is terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:

(a) Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium; or

(b) Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan or other HCA contracted vendor providing PEBB insurance coverage on behalf of the HCA, its employees, or other persons.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-209 Who is eligible for retiree term life insurance? Eligible employees who participate in public employees benefits board (PEBB) life insurance as an employee and eligible school employees who participate in school employees benefits board (SEBB) life insurance as an employee and meet qualifications for PEBB retiree insurance coverage as provided in WAC 182-12-171 or 182-12-180, are eligible for retiree term life insurance. They must submit the required forms to the PEBB program. Forms for a retiring

employee or a retiring school employee as described in WAC 182-12-171, must be received by the PEBB program no later than sixty days after the date their PEBB or SEBB employee life insurance ends. Forms for an official leaving public office as described in WAC 182-12-180, must be received by the PEBB program no later than sixty days after the official leaves public office.

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

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

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

(a) To continue to self-pay premiums and keep retiree term life insurance, the employee or the school employee must pay retiree term life insurance premiums directly to the contracted vendor during the period they are eligible for PEBB or SEBB employee life insurance; or

(b) To stop self-paying retiree term life insurance premiums during the period they are eligible for PEBB or SEBB employee life insurance and reelect retiree term life insurance when they are no longer eligible for the employer contribution toward PEBB or SEBB employee life insurance.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

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

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

(c) The employee or the school employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under their higher education retirement plan (HERP), with exceptions described below from WAC 182-12-171(2):

(i) A retiring employee of a state agency, ((~~Washington state school district, Washington state educational service district, Washington state charter school, or~~)) an employer group participating under a Washington state sponsored retirement plan, or a retiring school employee who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee of a state agency, ((~~Washington state school district, Washington state educational service district, Washington state charter school, or~~)) an employer group participating under a Washington state sponsored retirement plan, or a retiring school employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(25)), must meet their Plan 3 retirement eligibility criteria. The employee or the school employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage; or

(iii) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service.

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

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

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

(3) The director may make an exception to the date of PEBB retiree insurance coverage ((~~begins~~)) described in subsection (2)(a) and (b) of this section; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

(4) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage.

(5) If a retiring employee or a retiring school employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee or the retiring school employee.

Exception: If a retiring employee or a retiring school employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee or a retiring school employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-260 Who are eligible dependents? To be enrolled in ((~~a health plan~~)) PEBB benefits, a dependent must be eligible under this section and the subscriber must

comply with enrollment procedures outlined in WAC 182-12-262.

The public employees benefits board (PEBB) program verifies the eligibility of all dependents and will request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB program reserves the right to review a dependent's eligibility at any time. The PEBB program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB program is unable to verify a dependent's eligibility. The PEBB program will not enroll ((~~or reenroll~~)) dependents into ((~~a health plan~~)) PEBB benefits if the PEBB program is unable to verify a dependent's eligibility within the PEBB program enrollment timelines.

The subscriber must ((~~notify the PEBB program~~)) provide notice, in writing, when their dependent is not eligible under this section((~~. The notification must be received by the PEBB program no later than sixty days after the date their dependent is no longer eligible under this section. See~~)) as described in WAC 182-12-262 (2)(a) ((~~for the consequences of not removing an ineligible dependent from PEBB insurance coverage~~)).

The following are eligible as dependents:

(1) Legal spouse. A former spouse((~~s are~~)) is not an eligible dependent((~~s~~)) upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse((~~.~~));

(2) State registered domestic partner. ((~~State registered domestic partner as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.~~)) A former state registered domestic partner((~~s are~~)) is not an eligible dependent((~~s~~)) upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner((~~.~~));

(3) Children. Children are eligible through the last day of the month in which their twenty-sixth birthday occurred except as described in (((~~h~~))) (g) of this subsection. Children are defined as the subscriber's:

(a) Children based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated;

(b) Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to ((~~a~~)) the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

(c) ((~~Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of the child;~~

(~~d~~))) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(((~~c~~))) (d) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(((~~f~~))) (e) Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

(((~~g~~))) (f) Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

(((~~h~~))) (g) Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of twenty-six:

(i) The subscriber must provide proof of the disability and dependency within sixty days of the child's attainment of age twenty-six;

(ii) The subscriber must ((~~agree to~~)) notify the PEBB program, in writing, ((~~no later than sixty days after the date that~~)) when the child is no longer eligible under this subsection as described in WAC 182-12-262 (2)(a);

(iii) A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self-support;

(iv) A child with a developmental or physical disability age twenty-six and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if they later become incapable of self-support; and

(v) The PEBB program with input from the applicable contracted vendor will periodically verify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday, which may require renewed proof from the subscriber.

(4) Parents.

(a) Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(i) The parent maintains continuous enrollment in PEBB medical;

(ii) The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;

(iii) The subscriber continues enrollment in PEBB insurance coverage; and

(iv) The parent is not covered by any other group medical plan.

(b) Parents eligible under this subsection may be enrolled with a different health plan than that selected by the subscriber. Parents may not add additional dependents to their PEBB insurance coverage.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) benefits.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll their dependent except as provided in WAC 182-12-205 (3)(c). Subscribers must satisfy the enrollment requirements as described in subsection (4) of this section and may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in ((~~public employees benefits board (~~))PEBB((~~)~~)) benefits. If eligibility is verified and the dependent is enrolled, the dependent's effective date will be the same as the subscriber's effective date, except if the ((~~employee~~)) subscriber enrolls a newborn child in ((~~optional~~)) supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance. The newborn child's dependent life insurance and AD&D insurance coverage will be effective on the date the child becomes fourteen days old((~~,~~));

(b) **During the annual open enrollment.** PEBB ((~~health plan~~)) coverage begins January 1st of the following year((~~,~~)); or

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection (3) of this section.

(2) **Removing dependents from a subscriber's health plan coverage.**

(a) **A dependent's eligibility for enrollment in health plan coverage ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. ((~~Employees~~)) Subscribers must ((~~notify their employing agency~~)) provide notice when a dependent is no longer eligible due to divorce, annulment, dissolution, or qualifying event of a dependent ceasing to be eligible as a dependent child, as described in WAC 182-12-260(3). The notice must be received within sixty days of the last day of the month the dependent loses eligibility for health plan coverage. Employees must notify their employing agency when a dependent is no longer eligible, except as required under WAC 182-12-260 (3)(g)(ii). All other subscribers must notify the PEBB program ((~~when a dependent is no longer eligible~~)). Consequences for not submitting notice within the required sixty days ((~~of the last day of the month the dependent loses eligibility for health plan coverage may~~)) include, but are not limited to:

(i) The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility as described in WAC 182-12-270;

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and

(iv) The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

(b) **Employees have the opportunity to remove eligible dependents:**

(i) During the annual open enrollment. The dependent will be removed the last day of December; or

(ii) During a special open enrollment as described in subsections (3) and (4)(f) of this section.

(c) **Retirees (see WAC 182-12-171, 182-12-180, or 182-12-211), survivors (see WAC 182-12-180, 182-12-250, or 182-12-265), and ((~~enrollees with~~)) PEBB continuation coverage ((~~as described in~~)) enrollees (see WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148) may remove dependents** from their PEBB insurance coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. The dependent will be removed from the subscriber's PEBB insurance coverage prospectively. PEBB insurance coverage will end on the last day of the month in which the written notice is received by the PEBB program or on the last day of the month specified in the subscriber's written notice, whichever is later. If the written notice is received on the first day of the month, coverage will end on the last day of the previous month.

(3) **Special open enrollment.**

(a) Subscribers may enroll or remove their eligible dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code ((~~IRC~~)) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both.

(i) ((~~Health plan~~)) PEBB benefits coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

(ii) Enrollment of an extended dependent or a dependent with a disability will be the first day of the month following the later of the event date as described in WAC 182-08-198(2) or eligibility certification.

(iii) The dependent will be removed from the subscriber's health plan coverage the last day of the month following the later of the event date or the date the required form and proof of the event is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(iv) If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, ((~~health plan~~)) PEBB benefits coverage will begin or end as follows:

• For the newly born child, ((~~health plan~~)) PEBB benefits coverage will begin the date of birth;

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

• For a spouse or state registered domestic partner of a subscriber, ((~~health plan~~)) PEBB benefits coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed

from health plan coverage the last day of the month in which the event occurred;

A newly born child must be at least fourteen days old before ((~~optional~~)) supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective.

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

(b) Subscriber acquires a new dependent due to:

(i) Marriage or registering ((~~for~~)) a state registered domestic partnership;

(ii) Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

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

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

(e) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

((~~**Exception:**~~)) **Note:** ((~~For the purposes of special open enrollment~~)) As used in (e) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

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

(g) Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance;

(h) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

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

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

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** ((~~Employees~~)) An employee must submit the required forms to their employing agency((~~. All other~~)), a subscriber((~~s~~)) on continuation coverage or PEBB retiree insurance coverage must submit the required forms to the PEBB program. In addition to the required forms indicating dependent enrollment, the subscriber must provide the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment. All required forms and documents must be received within the required time frames.

(a) If a subscriber wants to enroll their eligible dependents when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms ((~~that the subscriber submits~~)) and submit them within the ((~~relevant~~)) required time frame described in WAC 182-08-197, 182-08-187, 182-12-171, 182-12-180, 182-12-211, or 182-12-250.

(b) If a subscriber wants to enroll eligible dependents during the PEBB annual open enrollment period, the required forms must be received no later than the last day of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the required forms must be received no later than sixty days after the dependent becomes eligible ((~~except as provided in (d) of this subsection~~)).

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received no later than ((~~twelve months~~)) sixty days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability, the required forms must be received no later than sixty days after the last day of the month in which the child reaches age twenty-six or within the relevant time frame described in WAC 182-12-262 (4)(a), (b), and (f). To recertify an enrolled child with a disability, the required forms must be received by the PEBB program or the contracted vendor by the child's scheduled PEBB coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status during a special open enrollment, the required forms must be received no later than sixty days after the event that creates the special open enrollment.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-263 National Medical Support Notice (NMSN). (1) When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(((~~1~~))) (a) The subscriber may enroll their dependent child and request changes to their health plan coverage as described under subsection (((~~3~~))) (c) of this section. Employees submit the required forms to their employing agency. ((~~All other~~)) Subscribers on continuation coverage or PEBB retiree insurance coverage submit the required forms to the public employees benefits board (PEBB) program.

(((~~(2)~~))) (b) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB program may make enrollment or health plan coverage changes according to ((~~subsection (3)~~)) (c) of this ((~~section~~)) subsection upon request of:

(((~~(a)~~))) (i) The child's other parent; or

(((~~(b)~~))) (ii) Child support enforcement program.

(((~~(3)~~))) (c) Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

(((~~(a)~~))) (i) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN;

(((~~(b)~~))) (ii) An employee who has waived PEBB medical under WAC 182-12-128 will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;

(((~~(c)~~))) (iii) The subscriber's selected health plan will be changed if directed by the NMSN;

(((~~(d)~~))) (iv) If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN((~~.~~

~~(e)~~)); or

(v) If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

(((~~(4)~~))) (d) Changes to health plan coverage or enrollment as described in ((~~subsection (3)(a)~~)) (c)(i) through (((~~(c)~~))) (iii) of this ((~~section~~)) subsection will begin the first day of the month following receipt by the employing agency of the NMSN. If the NMSN is received by the employing agency on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in ((~~subsection (3)(d)~~)) (c)(iv) of this ((~~section~~)) subsection the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(((~~(5) The subscriber may be eligible to make changes to their health plan enrollment and salary reduction elections related to the NMSN as described in WAC 182-08-198(2), 182-08-199(3), 182-12-128(4), or 182-12-262(3).~~)) (2) When a NMSN requires a spouse, former spouse, or other individual to provide coverage for a dependent enrolled in PEBB coverage and that coverage is in fact provided, the dependent may be removed from the subscriber's PEBB insurance coverage prospectively.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-265 What options for continuing health plan enrollment are available to a surviving spouse, state registered domestic partner, or child, if ((~~the~~)) an employee, a school employee, or a retiree dies? The survivor of an eligible employee, an eligible school employee, or a retiree who meets the eligibility criteria and submits the required forms as described in subsection (1), (2), or (3) of this section is eligible to enroll or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage. If enrolling in PEBB retiree insurance coverage, the survivor's first premium payment and applicable premium surcharges ((~~is~~)) are due to the health care authority (HCA) no later than forty-five days after the election period ends as described in subsection (1), (2), or (3) of this section. Following the survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(c).

(1) An employee's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system. To satisfy the requirement to immediately receive a monthly retirement benefit they must begin receiving monthly benefit payments no later than one hundred twenty days from the date of death of the employee. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

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

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

Notes: If a spouse, state registered domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, they may continue health plan enrollment as described in WAC 182-12-146.

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

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

(2) A retiree's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible retiree may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death.

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

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

(c) If a spouse, state registered domestic partner, or child of an eligible retiree is not enrolled in a PEBB health plan at the time of the retiree's death, the survivor is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the survivor must provide evidence of continuous enrollment in medical coverage as described in WAC 182-

12-205 from the most recent open enrollment for which the survivor was not enrolled in a PEBB medical plan prior to the retiree's death.

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

(3) ((~~The~~)) A school employee's spouse, state registered domestic partner, or child ((~~of a deceased school district, educational service district, or a charter school employee is eligible to~~)) who loses eligibility due to the death of an eligible school employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the school employee's death, provided the employee died on or after October 1, 1993. The survivor must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the school employee's death or the date the survivor's ((~~school district coverage,~~)) educational service district coverage, or ((~~charter~~)) school employees benefits board (SEBB) insurance coverage ends.

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

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

Note: If a spouse, state registered domestic partner, or child of an eligible school employee is not eligible for a retirement benefit allowance, they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, a spouse, state registered domestic partner, or child of an eligible school employee enrolled in SEBB insurance coverage may continue health plan enrollment as described in WAC 182-31-090.

(4) If ((~~a~~)) premiums and applicable premium surcharges received by the HCA ((~~is~~)) are sufficient as described in WAC 182-08-180 (1)(d)(ii) to maintain PEBB health plan enrollment after the ((~~employee's~~)) employee, school employee, or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

If the survivor's enrollment ended due to the death of the employee, school employee, or retiree, the PEBB program will reinstate the survivor's enrollment without a gap subject to payment of premium and applicable premium surcharges.

(5) If a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the survivor.

Exception: If a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

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

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the premiums and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The dependent's first premium payment and applicable premium surcharges ((~~is~~)) are due to the HCA no later than forty-five days after the election period ends as described in WAC 182-12-146, 182-12-180, 182-12-250, or 182-12-265, whichever applies. Following the ((~~employee's~~)) dependent's first premium payment, the dependent must pay premium and applicable premium surcharge amounts associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharges remain unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges ((~~was~~)) were paid as described in WAC 182-08-180 (1)(c). The PEBB program must receive the required forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment as described in WAC 182-12-180, 182-12-250, or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-12-260 are eligible to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

Note: Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, ((~~an employee's~~)) a subscriber's state registered domestic partner and the state registered partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.

(3) No continuation coverage will be offered unless the PEBB program is notified through hand-delivery or United States Postal Service mail of the qualifying event as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*.

AMENDATORY SECTION (Amending WSR 18-20-117, filed 10/3/18, effective 1/1/19)

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

(1) All subscribers, except PEBB subscribers who are enrolled in both medicare Parts A and B, and in the medicare risk pool as described in RCW 41.05.080(3), are eligible to participate in the PEBB wellness incentive program.

(2) Effective January 1, ((~~2016~~)) 2020, to receive the PEBB wellness incentive of a reduction to the subscriber's medical plan deductible or a deposit to the subscriber's health savings account for the following plan year, eligible subscribers must complete PEBB wellness incentive program requirements during the current plan year by the ((~~latest date below~~)) following deadline:

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

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

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

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

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

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

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

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

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

(c) Specific appropriations are provided for wellness incentives.

Chapter 182-16 WAC

APPEALS PRACTICE AND PROCEDURE

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-010 Purpose. This chapter describes the general rules and procedures that apply to the health care authority's brief adjudicative proceedings and formal administrative hearings for the public employees benefits board program.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

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

"Accidental death and dismemberment insurance" or "AD&D" means basic accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as supplemental accidental death and dismemberment insurance offered to and paid for by employees for themselves and their dependents.

"Appellant" means a person ((~~or entity~~)) who requests a ((~~review by~~)) brief adjudicative proceeding with the PEBB appeals unit ((~~or a formal administrative hearing~~)) about the action of the employing agency, the HCA, or its contracted vendor.

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

"Brief adjudicative proceeding" means the process described in RCW 34.05.482 through 34.05.494 and in WAC 182-16-2000 through 182-16-2160.

"Business days" means all days except Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

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

"Continuance" means a change in the date or time of when a brief adjudicative proceeding or formal administrative hearing will occur.

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

"Denial" or "denial notice" means an action by, or communication from, ((~~either~~)) an employing agency, contracted vendor, or the PEBB program that aggrieves a subscriber, a dependent, or an applicant, with regard to PEBB benefits including, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent

children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state ((~~and public~~)) employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Dispositive motion" means a motion made to a presiding officer, review officer, or hearing officer to decide a claim or case in favor of the moving party without further proceedings.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization((~~, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization~~)); (c) through December 31, 2019, employees of a school district or represented employees of an educational service district if the authority agrees to provide any of the school districts' or educational service districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); ((~~and~~)) (f) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW; and (g) through December 31, 2023, nonrepresented employees of an educational service district. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

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

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, ((~~school districts, educational service districts, and~~)) employee organizations representing state civil service employees, and through December 31, 2019, school districts and charter schools, and through December 31, 2023, educational service districts obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees benefits board as described in WAC 182-08-245.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, ((~~school district, educational service district,~~)) or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"File" or "filing" means the act of delivering documents to the office of the presiding officer, review officer, or hearing officer. A document is considered filed when it is received by the authority or its designee.

"Final order" means an order that is the final ((~~PEBB program~~)) health care authority decision.

"Formal administrative hearing" means a proceeding before a hearing officer that gives an appellant an opportunity for an evidentiary hearing as described in RCW 34.05.413 through 34.05.476 and WAC 182-16-3000 through 182-16-3200.

"HCA hearing representative" means a person who is authorized to represent the PEBB program in a formal administrative hearing. The person may be an assistant attorney general or authorized HCA employee.

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

"Hearing officer" means an impartial decision maker who presides at a formal administrative hearing, and is:

• A director-designated HCA employee; or

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

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

"Life insurance" ((~~for eligible employees includes~~)) means basic life insurance ((~~and accidental death and dis-~~

~~memberment (AD&D) insurance~~)) paid for by the employing agency, as well as ((~~optional~~)) supplemental life insurance ((~~and optional AD&D insurance~~)) offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"Long-term disability insurance" or "LTD insurance" ((~~includes~~)) means basic long-term disability insurance paid for by the employing agency and supplemental long-term disability insurance offered to and paid for by the employee((~~s on an optional basis~~)).

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state ((~~and public~~)) employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan established under ((~~this~~)) chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"PEBB" means the public employees benefits board.

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

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

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

"Prehearing conference" means a proceeding scheduled and conducted by a hearing officer to address issues in preparation for a formal administrative hearing.

"Premium payment plan" means a benefit plan whereby ((~~state and~~)) public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under chapter 41.05 RCW pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

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

• The spouse's or state registered domestic partner's share of the medical premiums is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and

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

"Presiding officer" means an impartial decision maker who conducts a brief adjudicative proceeding and is a director-designated HCA employee.

"Public employee" has the same meaning as employee.

"Review officer or officers" means one or more delegates from the director that consider appeals relating to the administration of PEBB benefits by the PEBB program.

"Salary reduction plan" means a benefit plan whereby ((~~state and~~)) public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (((~~DCAP~~))), medical flexible spending arrangement (((~~FSA~~))), or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Service" or "serve" means the process described in WAC 182-16-058.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government((~~, and all personnel thereof~~)). It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education, and any unit of state government established by law.

"State registered domestic partner" has the same meaning as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, or state agency, ((~~or charter school~~)) is enrolled in PEBB benefits, and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of an enrollee((~~s~~)).

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

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

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

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-055 Mailing address changes. (1) During the appeal process if the appellant's mailing address changes, the appellant must notify the public employees benefits board (PEBB) appeals unit as soon as possible.

(2) If the appellant does not notify the PEBB appeals unit of a change in the appellant's mailing address and the PEBB appeals unit continues to serve notices and other important documents to the appellant's last known mailing address, the documents will be deemed served on the appellant.

(3) This requirement to provide notice of an address change is in addition to WAC ((~~182-08-198, 182-08-199, 182-12-128, and 182-12-262~~)) 182-08-191 that require a subscriber to update their address.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-064 Applicable rules and laws. (1) An employing agency must apply public employees benefits board (PEBB) program rules adopted in the Washington Administrative Code (WAC) and follow instructions from the authority.

(2) A presiding officer, review officer or officers, or hearing officer must first apply the applicable ((~~public employees benefits board (~~))PEBB((~~)~~)) program rules adopted in the ((~~Washington Administrative Code (~~))WAC((~~)~~)). If no PEBB program rule applies, the presiding officer, review officer or officers, or hearing officer must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, significant decisions indexed as described in WAC 182-16-130, and court decisions.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-066 Burden of proof, standard of proof, and presumptions. (1) The burden of proof is a party's responsibility to provide evidence regarding disputed facts and persuade the presiding officer, review officer or officers, or hearing officer that a position is correct based on the standard of proof. Unless stated otherwise in rules or law, the appellant has the burden of proof in a brief adjudicative proceeding or formal administrative hearing.

(2) Standard of proof refers to the amount of evidence needed to prove a party's position. Unless stated otherwise in rules or law, the standard of proof in a brief adjudicative proceeding or formal administrative ((~~in a~~)) hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and agencies are presumed to have properly performed their duties and acted as described in the law, unless substantial evidence to the contrary is presented. A party challenging this presumption bears the burden of proof.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-120 Computation of time. (1) In computing any period of time prescribed by this chapter, the day of the event from which the time begins to run is not included. (For example, if an initial order is served on ((~~Tuesday~~)) Friday and the party has twenty-one days to request a review, start counting the days with ((~~Wednesday.~~)) Saturday.)

(2) ((~~Except~~)) As provided in subsection (3) of this section, the last day of the period so computed is included unless it is a Saturday, Sunday, or legal holiday as defined in RCW 1.16.050, in which case the period extends to the end of the next business day.

(3) When the period of time prescribed or allowed is ((~~less than~~)) ten days or less, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation.

(4) The deadline is 5:00 p.m. on the last day of the computed period.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-130 Index of significant decisions. (1) A final decision may be relied upon, used, or cited as precedent by a party only if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) An index of significant decisions is available to the public on the health care authority's (HCA) web site. As decisions are indexed they will be available on the web site.

(3) A final decision published in the index of significant decisions may be removed from the index when:

(a) A published decision entered by the court of appeals or the supreme court reverses an indexed final decision; or

(b) HCA determines that the indexed final decision is no longer precedential due to changes in statute, rule, or policy.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2000 Brief adjudicative proceedings. Pursuant to RCW 34.05.482, the authority will use brief adjudicative proceedings for issues identified in this chapter when doing so would not violate law, or when protection of the public interest does not require the authority to give notice and an opportunity to participate to persons other than the parties, or the issue and interests involved in the controversy do not warrant use of the procedures of RCW 34.05.413 through ((~~34.05.479~~)) 34.05.476 which govern formal administrative hearings.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2010 ((~~Where to appeal~~)) Appealing a decision regarding public employees benefits board (PEBB) eligibility, enrollment, premium payments, premium surcharges, a ((~~public employees benefits board (PEBB)~~)) wellness incentive, or the administration of benefits((~~?~~)). (1) Any current or former employee of a state agency or their dependent aggrieved by a decision made by the state agency with regard to public employees benefits board (PEBB) eligibility, enrollment, or premium surcharges may appeal that decision to the state agency by the process ((~~outlined~~)) described in WAC 182-16-2020.

Note: Eligibility decisions address whether a subscriber or a subscriber's dependent is entitled to PEBB ((~~insurance coverage~~)) benefits, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies including, but not limited to, the submission of proper documentation and meeting enrollment deadlines.

(2) Any current or former employee of an employer group or their dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility, enrollment, or premium surcharges may appeal that decision to the employer group through the process established by the employer group.

Exception: Any current or former employee of an employer group aggrieved by a decision regarding life insurance, long-term disability (LTD) insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may appeal that decision to the PEBB appeals ((~~committee~~)) unit by the process described in WAC 182-16-2030.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to PEBB eligibility, enrollment, premium payments, premium surcharges, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may appeal that decision to the PEBB appeals unit by the process described in WAC 182-16-2030.

(4) Any ((~~PEBB~~)) enrollee aggrieved by a decision regarding the administration of a health plan, life insurance, accidental death and dismemberment (AD&D) insurance, or long-term disability insurance may appeal that decision by following the appeal provisions of those plans, with the exception of:

(a) Enrollment decisions;

(b) Premium payment decisions other than life insurance or AD&D insurance premium payment decisions; and

(c) Eligibility decisions.

(5) Any PEBB enrollee aggrieved by a decision regarding the administration of PEBB long-term care insurance or property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(6) Any PEBB employee aggrieved by a decision regarding the administration of a benefit offered under the state's salary reduction plan may appeal that decision by the process described in WAC 182-16-2050.

(7) Any subscriber aggrieved by a decision made by the PEBB wellness incentive program contracted vendor regarding the completion of the PEBB wellness incentive program requirements, or a request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision by the process described in WAC 182-16-2040.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2020 ((~~How can a current or former employee or an employee's dependent appeal~~)) Appealing a decision made by a state agency about eligibility, premium surcharges, or enrollment in benefits((~~?~~)). (1) An eligibility, premium surcharges, or enrollment decision made by a state agency may be appealed by submitting a written request for administrative review to the state agency. The state agency must receive the request for administrative review no later than thirty days after the date of the denial notice. The contents of the request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the request for administrative review, the state agency ((~~shall~~)) must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial. ((~~As part of the administrative review, the state agency may hold a formal meeting or formal administrative hearing, but is not required to do so.~~))

(b) The state agency ((~~shall~~)) must render a written decision within thirty days of receiving the request for administrative review. The written decision ((~~shall~~)) must be sent to the employee or employee's dependent who submitted the request for administrative review and must include a description of appeal rights. The state agency ((~~shall~~)) must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the public employees benefits board (PEBB) appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the thirty-first day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(c) The state agency may reverse eligibility, premium surcharges, or enrollment decisions ((~~based only on circumstances that arose due to delays caused by the state agency or errors made by the state agency~~)) as permitted by WAC 182-08-187.

(2) Any current or former employee or employee's dependent who disagrees with the state agency's decision in response to a written request for administrative review, as described in subsection (1) of this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the requested documentation and information. The state agency will also send a copy of the documentation and information to the ((~~employee, former employee, or the employee's dependent~~)) appellant.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal the state agency's written deci-

sion within thirty days by following the process in (a) of this subsection, the state agency's prior written decision becomes the health care authority's final decision without further action.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group((~~?~~)). (1) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(2) A decision made by an employer group regarding life insurance, LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(3) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(4) The request for a brief adjudicative proceeding from a current or former employee or employee's dependent must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice.

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

(6) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(7) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(8) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within the applicable time frame described in subsections (4) and (5) of this section, will result in the prior PEBB program decision becoming the authority's final decision without further ((~~employing agency~~)) action.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements? (1) Any subscriber aggrieved by a decision regarding the completion of the wellness incentive program requirements, or request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision to the public employees benefits board (PEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the PEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the PEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former employee must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(b) The request for a brief adjudicative proceeding from a retiree or self-pay subscriber must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) If a subscriber fails to timely request a brief adjudicative proceeding of a decision made under subsection (1) of this section within thirty days by following the process in WAC 182-16-2020(2), the decision of the PEBB wellness incentive program contracted vendor becomes the authority's final decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2050 How can an employee ((~~who is eligible to participate in the state's salary reduction plan~~)) appeal a decision regarding the administration of benefits offered under the ((~~state's~~)) salary reduction plan? (1) Any employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the ((~~state's~~)) salary reduction plan may appeal that decision by submitting a written request for administrative review to their state agency. The state agency must receive the written request for administrative review no later than thirty days after the date of the denial. The contents of the written request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the written request for administrative review, the state agency ((~~shall~~)) must perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The state agency ((~~shall~~)) must render a written decision within thirty days of receiving the request for administrative review. The written decision ((~~shall~~)) must be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency ((~~shall~~)) must also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the PEBB appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied as of the thirty-first day and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(2) Any employee who disagrees with the state agency's decision in response to a written request for administrative review, as described in this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the documentation and information requested. The state agency will also send a copy of the documentation and information to the employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the state agency's prior written decision becomes the authority's final decision without further ((~~state agency~~)) action.

(3) Any employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the ((~~state's~~)) salary reduction plan may appeal that decision to the authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any employee who disagrees with a decision in response to an appeal filed with the contracted vendor that administers the medical FSA and DCAP under the ((~~state's~~)) salary reduction plan may request a brief adjudicative proceeding by submitting a written request to the PEBB appeals unit. The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the contracted vendor's appeal decision. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the contracted vendor's prior written decision becomes the authority's final decision.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the ((~~state's~~)) salary reduction plan may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit for a brief adjudicative proceeding.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice by the PEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the notice of appeal has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the PEBB program's prior written decision becomes the authority's final decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? (1) An entity or organization whose employer group application is denied by the authority may appeal the decision by submitting a request for a brief adjudicative proceeding to the public employees benefits board (PEBB) appeals unit. For rules regarding eligible entities, see WAC 182-12-111.

(2) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit ((~~shall~~)) must notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in subsection (2) of this section, will result in the prior PEBB program decision becoming the authority's final decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2080 Who can appeal or represent a party in a brief adjudicative proceeding? (1) The appellant may act as their own representative or may choose to be represented by another person, except that employees of the health care authority (HCA) or HCA's authorized agents may not represent an appellant, unless approved by a presiding officer or review officer.

(2) If the appellant is represented by a person who is not an attorney admitted to practice in Washington state, the representative must provide the presiding officer and other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the PEBB appeals unit

and other parties with a signed, written consent permitting release to the nonattorney representative of the appellant's ((~~personal~~)) health information protected by state or federal law.

(3) An attorney admitted to practice law in Washington state representing the appellant must file a written notice of appearance containing the attorney's name, address, and telephone number with the presiding officer's office and serve all parties with the notice. In cases involving confidential information, the attorney must provide the PEBB appeals unit and other parties with a signed, written consent permitting release to the attorney of the appellant's ((~~personal~~)) health information protected by state or federal law. If the appellant's attorney representative no longer represents the appellant, then the attorney must file a written notice of withdrawal of representation with the presiding officer or review officer or officers' office and serve all parties with the notice.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2085 Continuances. The presiding officer or review officer or officers may grant, in their sole discretion, a request for a continuance on motion of the appellant, the authority, or on ((~~its~~)) their own motion. The continuance may be up to thirty calendar days.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2090 Initial order. Unless a continuance has been granted, within ten days after the PEBB appeals unit receives a request for a brief adjudicative proceeding, the presiding officer shall render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The presiding officer ((~~shall~~)) must serve a copy of the initial order on all parties and the initial order ((~~shall~~)) must contain information on how the appellant may request review of the initial order.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2100 How to request a review of an initial order resulting from a brief adjudicative proceeding. (1) An appellant who has received an initial order upholding an employing agency decision, public employees benefits board (PEBB) program decision, or a decision made by PEBB program contracted vendor, may request review of the initial order by the authority. The appellant must file a written request for review of the initial order or ((~~by making~~)) make an oral request for review of the initial order with the ((~~public employees benefits board (~~))PEBB((~~)~~)) appeals unit within twenty-one days after service of the initial order. The written or oral request for review of the initial order must be ((~~provided~~)) made by using the contact information included in the initial order. If the appellant fails to request review of the initial order within twenty-one days, the order becomes the final order without ((~~any~~)) further action by the authority.

(2) Upon timely request by the appellant, a review of an initial order will be performed by one or more review officers designated by the director of the authority.

(3) If the ((~~parties have~~)) appellant has not requested review, the authority may review an order resulting from a brief adjudicative proceeding on its own motion, and without notice to the parties, but it may not take action on review less favorable to any party than the initial order without giving that party notice and an opportunity to explain that party's view of the matter.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2105 Withdrawing the request for a brief adjudicative proceeding or review of an initial order. (1) The appellant may withdraw the request for a brief adjudicative proceeding or review of an initial order for any reason, and at any time, by contacting the public employees benefits board (PEBB) appeals unit. The PEBB appeals unit will present the withdrawal request to the presiding officer or review officer or officers.

(2) The request for withdrawal must be made in writing.

(3) After a withdrawal request is received, the presiding officer or review officer or officers must enter and serve a written order dismissing the ((~~appeal~~)) brief adjudicative proceeding or review of an initial order.

(4) If an appellant withdraws a request for a brief adjudicative proceeding or review of an initial order, the appellant may not reinstate the request for a brief adjudicative proceeding or review of an initial order unless time remains on their original appeal period.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2120 Request for reconsideration. (1) A request for reconsideration asks the review officer or officers to reconsider the final order because the party believes the review officer or officers made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the review officer or officers who entered the final order.

(4) If a party files a request for reconsideration:

(a) The review officer or officers must receive the request for reconsideration on or before the tenth business day after the service date of the final order.

(b) The party filing the request must send copies of the request to all other parties.

(c) Within five business days of receiving a request for reconsideration, the review officer or officers must serve all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the review officer or officers no later than seven business days after the service date of the review officer's or officers' notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the review officer or officers may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-2120 (4)(a), the same review officer or officers who entered the final order, if reasonably available, will also consider the request as well as any responses received.

(8) The decision on the request for reconsideration must be in the form of a written order denying the request, granting the request in whole or in part and issuing a new written final order, or granting the petition and setting the matter for further hearing.

(9) If the review officer or officers do not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in subsection (4)(c) of this section, the request is deemed denied.

(10) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a petition for reconsideration is not required before requesting judicial review.

(11) An order denying a request for reconsideration is not subject to judicial review.

(12) No evidence may be offered in support of a motion for reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have discovered and produced ((~~at the hearing or before the ruling on a dispositive motion~~)) prior to the final order being issued.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2130 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW ((~~34.05.546. The~~)) 34.05.510 through 34.05.598. Neither the public employees benefits board (PEBB) program nor the employing agency may ((~~not~~)) request judicial review.

((~~(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.~~))

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2140 Presiding officer—Designation and authority. The designation of a presiding officer ((~~shall~~)) must be consistent with the requirements of RCW 34.05.485 and the presiding officer ((~~shall~~)) must not have personally participated in the decision made by the employing agency or PEBB program.

(1) The presiding officer will decide the issue based on the information provided by the parties during the presiding officer's review of the appeal.

(2) A presiding officer is limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(3) A presiding officer may not decide that a rule is invalid or unenforceable.

(4) In addition to the record, the presiding officer may employ ((~~authority~~)) the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2150 Review officer or officers—Designation and authority. (1) The designation of a review officer or officers shall be consistent with the requirements of RCW 34.05.491 and the review officer or officers shall not have personally participated in the decision made by the employing agency or PEBB program.

(2) The review officer or officers shall review the initial order and the record to determine if the initial order was correctly decided.

(3) The review officer or officers will issue a final order that will either:

(a) Affirm the initial order in whole or in part;

(b) Reverse the initial order in whole or in part; or

(c) Refer the matter for a formal administrative hearing; or

(d) Remand to the presiding officer in whole or in part.

(4) A review officer or officers are limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(5) A review officer or officers may not decide that a rule is invalid or unenforceable.

(6) In addition to the record, the review officer or officers may employ ((~~authority~~)) the authority's expertise as a basis for the decision.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing. (1) The presiding officer or the review officer or officers, in their sole discretion, may convert a brief adjudicative proceeding to a formal administrative hearing at any time on motion by the subscriber or enrollee or their representative, the authority, or on the presiding officer or review officer or officers' own motion.

(2) The presiding officer or review officer or officers must convert the brief adjudicative proceeding to a formal administrative hearing when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the authority to give notice and an opportunity to participate to persons

other than the parties, or when the issues and interests involved in the controversy warrant the use of the procedures or RCW 34.05.413 through ((~~34.05.479~~)) 34.05.476 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director ((~~may become the hearing officer or may~~)) designates a ((~~replacement~~)) hearing officer to conduct the formal administrative hearing upon notice to the subscriber or enrollee and the authority.

(4) When a brief adjudicative proceeding is converted to a formal administrative hearing, WAC 182-16-010 through 182-16-130 and 182-16-3000 through 182-16-3200 apply to the formal administrative hearing.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3000 Formal administrative hearings. (1) When a brief adjudicative proceeding is converted to a formal administrative hearing consistent with WAC 182-16-2160, the director designates a hearing officer to conduct the formal administrative hearing.

(2) Formal administrative hearings are conducted consistent with the Administrative Procedure Act, RCW 34.05.413 through ((~~34.05.479~~)) 34.05.476.

(3) ((~~This~~)) Part III describes the general rules and procedures that apply to public employees benefits board (PEBB) benefits formal administrative hearings.

(a) ((~~This~~)) Part III supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules of procedure in chapter 10-08 WAC. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by the authority in public employees benefits board (PEBB) benefits formal administrative hearings. Other procedural rules adopted in chapters 182-08, 182-12, and 182-16 WAC are supplementary to the model rules of procedure.

(b) In the case of a conflict between the model rules of procedure and this part, the procedural rules adopted in this part ((~~shall~~)) must govern.

(c) If there is a conflict between this part and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08 and 182-12 WAC.

(d) Nothing in this part is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3010 Requirements to appear and represent a party in the formal administrative hearing process. (1) All parties must provide the hearing officer and all other parties with their name, address, and telephone number.

(2) The appellant may act as their own representative or have another person represent them, except that employees of the health care authority (HCA) or HCA's authorized agents may not represent an appellant, unless approved by a hearing officer.

(3) If the appellant is represented by a person who is not an attorney admitted to practice in Washington state, the representative must provide the hearing officer and all other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the HCA hearing representative with a signed, written consent permitting release to the nonattorney representative of ((~~personal~~)) health information protected by state or federal law.

(4) An attorney admitted to practice law in Washington state, who wishes to represent the appellant, must file a written notice of appearance containing the attorney's name, address, and telephone number with the hearing officer's office and serve all parties with the notice. In cases involving confidential information, the attorney representative must provide the HCA hearing representative with a signed, written consent permitting release to the attorney representative of the appellant's ((~~personal~~)) health information protected by state or federal law. If the appellant's attorney representative no longer represents the appellant, then the attorney must file a written notice of withdrawal of representation with the hearing officer's office and serve all parties with the notice.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3030 Authority of the hearing officer. (1) A hearing officer must hear and decide the issues ((~~de novo (anew)~~)) based on the evidence and oral or written arguments presented during a formal administrative hearing and admitted into the record.

(2) A hearing officer has no inherent or common law powers, and is limited to those powers granted by the state constitution, statutes, or rules.

(3) A hearing officer may not decide that a rule is invalid or unenforceable. If the validity of a rule is raised during a formal administrative hearing, the hearing officer may allow only argument to preserve the record for judicial review.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3080 Time requirements for service of notices made by the hearing officer. (1) The hearing officer or their designee must serve a notice of a formal administrative hearing to all parties and their representatives at least twenty-one calendar days before the hearing date. The parties may agree to, but the hearing officer cannot impose, a shorter notice period.

(2) If a prehearing conference or dispositive motion hearing is scheduled, the hearing officer must serve a notice of the prehearing conference or dispositive motion hearing to the parties and their representatives at least seven business days before the date of the prehearing conference or dispositive motion hearing except:

(a) The hearing officer may change any scheduled formal administrative hearing into a prehearing conference or dispositive motion hearing and provide less than seven busi-

ness days' notice of the prehearing conference or dispositive motion hearing; and

(b) The hearing officer may give less than seven business days' notice if the only purpose of the prehearing conference is to consider whether to grant a continuance.

(3) The hearing officer must reschedule a formal administrative hearing if necessary to comply with the notice requirements in Part III of this ((~~section~~)) chapter.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3100 Rescheduling and continuances for formal administrative hearings. (1) Any party may request the hearing officer to reschedule a formal administrative hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The hearing officer must reschedule the hearing under circumstances identified in ((~~subsection (1) of~~)) this ((~~section~~)) chapter if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a formal administrative hearing either orally or in writing.

(a) In each formal administrative hearing, the hearing officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The hearing officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances ((~~established at a proceeding~~)).

(c) After granting a continuance, the hearing officer or their designee must:

(i) Immediately telephone all other parties to inform them the hearing was continued; and

(ii) Serve an order of continuance on the parties no later than fourteen days before the new formal administrative hearing date. All orders of continuance must provide a new deadline for filing documents with the hearing officer. The new filing deadline can be no less than ten calendar days prior to the new formal administrative hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the hearing officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection ((~~(1)~~)) (2)(b) of this section, the hearing officer must grant a continuance if a new material issue is raised during the formal administrative hearing and a party requests a continuance.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3120 Dispositive motions. (1) A dispositive motion could dispose of one or all the issues in a formal administrative hearing, such as a motion to dismiss or motion for summary judgment.

(2) To request a dispositive motion hearing a party must file a written dispositive motion with the hearing officer and serve a copy of the motion to all other parties. The hearing officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the hearing officer believes must be addressed before the hearing.

(3) The deadline to file a timely dispositive motion ((~~shall~~)) must be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a hearing officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the hearing officer at least ten calendar days before the date of the hearing; and

(ii) The party filing the dispositive motion has not previously filed a dispositive motion.

(b) May schedule a dispositive motion hearing in all instances other than described in (a) of this subsection.

(5) The hearing officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the HCA hearing representative may choose to attend and participate in person or by telephone conference call.

(6) The party requesting the dispositive motion hearing must attend and participate in the dispositive motion hearing in person or by telephone. If the party requesting the motion hearing does not attend and participate in the dispositive motion hearing, the hearing officer will enter an order ((~~of default~~)) dismissing the dispositive motion.

(7) During a dispositive motion hearing, the hearing officer can only consider the filed dispositive motions, any response to the motions, evidence submitted to support or oppose the motions, and argument on the motions. Prior to rescheduling any necessary hearings, the hearing officer must serve a written order on the dispositive motions.

(8) The hearing officer must serve the written order on the dispositive motions to all parties no later than eighteen calendar days after the dispositive motion hearing is held. Orders on dispositive motions are subject to motions for reconsideration or petitions for judicial review as described in WAC 182-16-2120 and 182-16-2130.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3130 Subpoenas. (1) Hearing officers, the HCA hearing representative, and attorneys for the parties may prepare subpoenas as described in Washington state civil rule 45, unless otherwise prohibited by law. Any party may request the hearing officer prepare a subpoena on their behalf.

(2) The hearing officer may schedule a prehearing conference to decide whether to issue a subpoena.

(3) If a party requests the hearing officer prepare a subpoena on its behalf, the party is responsible for:

(a) Service of the subpoena; and

(b) Any costs associated with:

(i) Compliance with the subpoena; and

(ii) Witness fees as described in RCW 34.05.446(7).

(4) Service of a subpoena must be made by a person who is at least eighteen years old and not a party to the hearing. Service of the subpoena is complete when the person serving the subpoena:

(a) Gives the person or entity named in the subpoena a copy of the subpoena; or

(b) Leaves a copy of the subpoena with a person over the age of eighteen at the residence or place of business of the person or entity named in the subpoena.

(5) To prove service of a subpoena on a witness, the person serving the subpoena must file with the hearing officer's office a signed, written, and dated statement that includes:

(a) The name of the person to whom service of the subpoena occurred;

(b) The date the service of the subpoena occurred;

(c) The address where the service of the subpoena occurred; and

(d) The name, age, and address of the person who provided service of the subpoena.

(6) A ((~~party~~)) person or entity subject to or affected by the subpoena may request the hearing officer quash (set aside) or change a subpoena request at any time before the deadline given in the subpoena.

(7) A hearing officer may quash (set aside) or change a subpoena if it is unreasonable.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal. (1) An order of dismissal is an order from the hearing officer ending the matter. The order is entered because the party who made the appeal withdrew from the proceeding, the appellant is no longer aggrieved, the hearing officer granted a dispositive motion dismissing the matter, or the hearing officer entered an order of default because the party who made the appeal failed to attend or refused to participate in a prehearing conference or the formal administrative hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order as described in subsections (3) through (7) of this section.

(3) If the hearing officer enters and serves an order dismissing the formal administrative hearing, the appellant may file a written request to vacate (set aside) the order of dismissal. Upon receipt of a request to vacate an order of dismissal, the hearing officer must schedule and serve notice of a prehearing conference as described in WAC 182-16-3080. At the prehearing conference, the party asking that the order of dismissal be vacated has the burden to show good cause according to subsection (8) of this section for an order of dismissal to be vacated and the matter to be reinstated.

(4) The request to vacate an order of dismissal must be filed with the hearing officer and the other parties. The party requesting that an order of dismissal be vacated should specify in the request why the order of dismissal should be vacated.

(5) The request to vacate an order of dismissal must be filed with the hearing officer no later than twenty-one calendar days after the date the order of dismissal was entered. If no request is received within that deadline, the dismissal order becomes ((~~a final order and the final order will stand~~)) the health care authority's final decision without further action.

(6) If the hearing officer finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated, the hearing officer must enter and serve a written order to the parties setting forth the findings of fact, conclusions of law, and reinstatement of the matter.

(7) If the order of dismissal is vacated, the hearing officer will conduct a formal administrative hearing at which the parties may present argument and evidence about issues raised in the original appeal. The formal administrative hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties and the hearing officer, otherwise a formal administrative hearing date must be scheduled by the hearing officer.

(8) Good cause is a substantial reason or legal justification for failing to appear, act, or respond to an action using the provisions of Superior Court civil rule 60 as a guideline. This good cause exception applies only to this chapter. This good cause exception does not apply to any other chapter or chapters in Title 182 WAC.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3160 Withdrawing a formal administrative hearing. (1) The appellant may withdraw a formal administrative hearing for any reason, and at any time, by contacting the health care authority (HCA) hearing representative who will coordinate the withdrawal with the hearing officer.

(2) The request for withdrawal must generally be made in writing. An oral withdrawal by the appellant is permitted during a formal administrative hearing when both the hearing officer and HCA hearing representative are present.

(3) After a withdrawal request is received, the hearing officer must cancel any scheduled hearings and enter and serve a written order dismissing the case.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3170 Final order deadline—Required information. (1) Within ninety days after the formal administrative hearing record is closed, the hearing officer ((~~shall~~)) must serve a final order that ((~~shall~~)) must be the final decision of the authority. The hearing officer shall serve a copy of the final order to all parties.

(2) The hearing officer must include the following information in the written final order:

(a) Identify the order as a final order of the public employees benefits board (PEBB) program;

(b) List the name and docket number of the case and the names of all parties and representatives;

(c) Enter findings of fact used to resolve the dispute based on the evidence admitted in the record;

(d) Explain why evidence is, or is not, credible when describing the weight given to evidence related to disputed facts;

(e) State the law that applies to the dispute;

(f) Apply the law to the facts of the case in the conclusions of law;

(g) Discuss the reasons for the decision based on the facts and the law;

(h) State the result and remedy ordered; and

(i) Include any other information required by law or program rules.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3180 Request for reconsideration and response—Process. (1) A request for reconsideration asks the hearing officer to reconsider the final order because the party believes the hearing officer made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the hearing officer who entered the final order.

(4) If a party files a request for reconsideration:

(a) The hearing officer must receive the request for reconsideration on or before the tenth business day after the service date of the final order((.));

(b) The party filing the request must serve copies of the request ((to)) on all other parties((.)) on the same day the request is served on the hearing officer; and

(c) Within five business days of receiving a request for reconsideration, the hearing officer must serve to all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the hearing officer no later than seven business days after the service date of the hearing officer's notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the hearing officer may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) No evidence may be offered in support of a motion for re-consideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not ((with reasonable diligence)) have reasonably discovered and produced at the hearing or before the ruling on a dispositive motion.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3190 Decisions on requests for reconsideration. (1) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-3180, the same hearing officer who entered the final order, if reasonably available, will also dispose of the request as well as any responses received.

(2) The decision on the request for reconsideration must be in the form of a written order denying or granting the request in whole or in part and if the request is granted issuing a new written final order.

(3) If the hearing officer does not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in WAC ((182-16-2120)) 182-16-3180 (4)(c), the request is deemed denied.

(4) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a request for reconsideration is not required before requesting judicial review.

(5) An order denying a request for reconsideration is not subject to judicial review.

AMENDATORY SECTION (Amending WSR 18-22-033, filed 10/29/18, effective 1/1/19)

WAC 182-16-3200 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW ((34.05.546)) 34.05.510 through 34.05.598. The public employees benefits board (PEBB) program may not request judicial review.

(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.

WSR 19-14-096
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE

[Filed July 1, 2019, 4:04 p.m.]

Continuance of WSR 19-11-130 filed on May 22, 2019.

Preproposal statement of inquiry was filed as WSR 19-03-137 filed January 22, 2019.

Title of Rule and Other Identifying Information: The department is considering amendments to current recreational fishing rules resulting from stakeholder recommendations made during North of Falcon meetings and to incorporate changes in the rules brought about from the department's freshwater recreational rule simplification project: WAC 220-312-020 Freshwater exceptions to statewide rules—Coast, 220-312-030 Freshwater exceptions to statewide rules—Southwest, 220-312-040 Freshwater exceptions to statewide rules—Puget Sound, 220-312-050 Freshwater

exceptions to statewide rules—Eastside, 220-312-060 Freshwater exceptions to statewide rules—Columbia River, 220-313-060 Puget Sound salmon—Saltwater seasons and daily limits, and 220-313-070 Coastal salmon—Saltwater seasons and daily limits.

Date of Intended Adoption: July 12, 2019.

Submit Written Comments to: Scott Bird, Washington Department of Fish and Wildlife (WDFW) Rules Coordinator, P.O. Box 43152, Olympia, WA 98501, email Rules.Coordinator@dfw.wa.gov, fax 360-902-2155, by July 10, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is filing a continuance to open up and extend the comment period which closed on June 24. The comment period will be open from July 1 through July 10, 2019, concerning this proposal. The department is providing the public the opportunity to comment on its changing the basis for the exemption to comply with the requirements of chapter 19.85 RCW.

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

Name of Proponent: WDFW, governmental.

Name of Agency Personnel Responsible for Drafting: Kelly Henderson, 1111 Washington Street, Olympia, WA 98501, 360-902-2684; Implementation: Ron Warren, 1111 Washington Street, Olympia, WA 98501, 360-902-2799; and Enforcement: Chief Steve Bear, 1111 Washington Street, Olympia, WA 98501, 360-902-2373.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rule does not affect hydraulics.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal: Is exempt under RCW 19.85.025(4).

Explanation of exemptions: The department listed an incorrect exemption on its previously filed proposal under WSR 19-11-130. The department is exempt from the requirements of chapter 19.85 RCW because the proposed recreational fishing rules do not regulate small businesses; rather, the department's proposed fishing rules regulate individuals who undertake recreational fishing activities. The statewide recreational rules that are the subject of this rule making simply govern the time, place and manner for individuals who want to enjoy the recreational fishing opportunities provided.

July 1, 2019
Scott Bird
Rules Coordinator

WSR 19-14-100
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed July 2, 2019, 9:20 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-08-001.

Title of Rule and Other Identifying Information: The department is proposing to add new sections, repeal existing sections, and amend sections in chapter 388-78A WAC, Assisted living facility licensing rules, to update physical plant requirements.

Hearing Location(s): On August 27, 2019, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than August 28, 2019.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAURulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., August 27, 2019.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by August 13, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: These rules needed updating to meet the national building code standards for licensed health care facilities of this type. With a moratorium on rule development, DSHS has not been able to keep the rules up-to-date in concert with the changes in building codes, energy efficiency standards, and the structural enhancements associated with this facility type across the nation. The regulatory amendments encompass the technological advances in building design, and the health care industry. This has a positive impact on the developers, architects, facility owners, and residents in new and currently licensed facilities to meet licensing requirements and building code requirements with updated safety standards.

Reasons Supporting Proposal: See purpose statement above.

Statutory Authority for Adoption: Chapters 18.20, 74.39A RCW.

Statute Being Implemented: None.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Jeanette K. Childress, P.O. Box 45600, Olympia, WA 98504-5600, 360-752-2591; and Enforcement: Dina Longen-Grimes, P.O. Box 45600, Olympia, WA 98504-5600, 360-752-2591.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Jeanette K. Childress, P.O. Box 45600, Olympia, WA 98504-5600, phone 360-725-2591, email Jeanette.Childress@dshs.wa.gov.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. Per the small

business economic impact statement/cost-benefit analysis, costs are offset by eliminating some of the building requirements, updating building requirements so [to] not have to install dual systems to meet building codes and licensing rules, and with increased electronic monitoring to potentially reduce facility liability, improve energy efficiency, and reduce insurance costs.

A copy of the detailed cost calculations may be obtained by contacting Jeanette K. Childress, P.O. Box 45600, Olympia, WA 98504-5600, phone 360-725-2591, email Jeanette.Childress@dshs.wa.gov.

June 26, 2019
Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 19-15 issue of the Register.

WSR 19-14-102
PROPOSED RULES
STATE BOARD OF HEALTH
[Filed July 2, 2019, 9:33 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-06-090.

Title of Rule and Other Identifying Information: Chapter 246-105 WAC, Immunization of child care and school children against certain vaccine-preventable diseases, the state board of health (board) will consider updating the rule regarding documentation of immunization status, the process for students who are in conditional status, the reference to the national immunization standards set by the advisory committee on immunization practices (ACIP), and improving clarity and usability.

Hearing Location(s): On August 14, 2019, at 1:50 p.m., at the John A. Cherberg Building, Senate Hearing Room 4, 304 15th Avenue S.W., Olympia, WA 98504.

Date of Intended Adoption: August 14, 2019.

Submit Written Comments to: Alexandra Montano, P.O. Box 47990, Olympia, WA 98504-7990, email https://fortress.wa.gov/doh/policyreview, fax 360-236-4088, by July 24, 2019.

Assistance for Persons with Disabilities: Contact Alexandra Montano, phone 360-236-4106, TTY 360-833-6388 or 711, email alexandra.montano@sboh.wa.gov, by July 24, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The board is proposing updating the rule to improve documentation of immunization status for school and child care entry by requiring medically verified immunization records. The current rule requires parents to report their child's immunizations on the certificate of immunization status before entry into schools and child care facilities. Eliminating additional data handoffs and ensuring immunizations are medically valid will help reduce immunization documentation errors in the Washington state immunization information system.

The proposed rule clarifies the process for conditional status. The board received requests from several school nurses in 2016 asking to change the rule to require students to be fully immunized before school entry. The board decided at the time not to engage in rule making and instead suggested that board and department of health (department) staff continue the discussion with stakeholders about strategies to reduce the administrative burden to schools while decreasing the number of children who are out of compliance with school immunization requirements. The existing rule is in alignment with RCW 28A.210.080 but because there have been issues with implementation and interpretation of the current language, as demonstrated by the petitions for rule making, the proposed rule clarifies this process. In the proposed rule, students are allowed to be in conditional status for thirty days from the first day of attendance if they have received all of the doses of immunizations they are eligible for, according to the requirements established in WAC 246-105-040, on or before the first day of attendance. When the immunizations are part of a series with recommended intervals between doses, students will have thirty calendar days past the recommended date of administration of the next dose to receive the missing immunization.

The current rule includes language that requires the certificate of exemption (COE) to have a place for the parent to sign to affirm that they belong to a church or religious body that precludes a health care practitioner from providing medical treatment, and a place to identify the name of the church or religious body. The department does not collect this religious affiliation information from schools so the proposed rule removes the requirement to have the parent identify the name of the church or religious body on the COE.

EHB 1638, which passed in 2019, removes the personal and philosophical exemption for the measles, mumps, and rubella (MMR) vaccine. The proposed rule aligns the exemption requirements in the rule with the provisions of EHB 1638.

The proposed rule also updates the reference to the national immunization standards set by ACIP from the 2017 publication to the current 2019 publication.

Reasons Supporting Proposal: Updating the rule will improve immunization documentation for children entering school or child care, help schools and child cares accurately determine immunization compliance, and provide accurate information for schools and child cares to determine if a child is adequately protected in case there is an outbreak of a vaccine-preventable disease. Clarifying the process for conditional status will also decrease the administrative burden expressed by school staff to track students lacking the required immunization documentation. Finally, EHB 1638 passed during the 2019 legislative session. This bill removes the personal and philosophical exemption for the MMR vaccine and will go into effect on July 28, 2019. The proposed rule aligns the exemption requirements in the rule with the provisions of EHB 1638.

Statutory Authority for Adoption: RCW 28A.210.140.

Statute Being Implemented: RCW 28A.210.080, 28A.210.100.

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

Name of Proponent: Washington state board of health, governmental.

Name of Agency Personnel Responsible for Drafting: Alexandra Montano, 101 Israel Road S.E., Tumwater, WA, 98504-7990, 360-236-4106; Implementation and Enforcement: Michele Roberts, 310 Israel Road S.E., Tumwater, WA 98504-7830, 360-236-3568.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Alexandra Montano, P.O. Box 47990, Olympia, WA 98504-7990, phone 360-236-4106, fax 360-236-4088, TTY 360-833-6388 or 711, email alexandra.montano@sboh.wa.gov.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. There are no costs associated with the proposed rules.

July 2, 2019
Michelle A. Davis
Executive Director

AMENDATORY SECTION (Amending WSR 14-06-037, filed 2/25/14, effective 3/28/14)

WAC 246-105-020 Definitions. ((~~For the purposes of this chapter, the words and phrases in this section have the following meanings~~)) The definitions in this section apply throughout this chapter unless the context clearly indicates otherwise:

(1) "Certificate of exemption (COE)" means a form for the purpose of documenting an exemption to the school or child care immunization requirements that is((~~:~~

~~(a)~~)) approved by the department and consistent with the requirements of WAC 246-105-050((~~(2); or~~

~~(b) An immunization form produced by the state immunization information system~~)) (4).

(2) "Certificate of immunization status (CIS)" means a form for the purpose of documenting a person's immunization status that is((~~:~~

~~(a)~~)) approved by the department and consistent with the requirements of WAC 246-105-050((~~(1); or~~

~~(b) An immunization form produced by the state immunization information system~~)) (2).

(3) "Chief administrator" means:

(a) The person with the authority and responsibility for supervising the immediate operation of a school or child care center; or

(b) A person designated in writing by the statutory or corporate board of directors of the school district or school; or

(c) If (a) and (b) of this subsection do not apply, a person or persons with the authority and responsibility for supervising the general operation of the school district or school.

(4) "Child" means any person regardless of age admitted to:

(a) Any public school district; or

(b) Any private school or private institution subject to approval by the state board of education or described in RCW 28A.305.130 and 28A.195.010 through 28A.195.060; or

(c) Any child care center.

(5) "Child care center" means any facility or center licensed by the department of ((~~early learning~~)) children, youth, and families under chapter ((~~43.215~~)) 43.216 RCW that regularly provides ((~~care for a group of thirteen or more children one month of age through twelve years of age~~)) early childhood education and early learning services for a group of children for periods of less than twenty-four hours per day.

(6) "Child care health consultant" means a licensed registered nurse meeting the qualifications established in WAC 110-300-0275 or their designee.

(7) "Conditional" means a type of temporary immunization status where a child is not fully immunized against one or more of the vaccine-preventable diseases required by this chapter ((~~for full immunization~~)). A child in this status is allowed to attend a school or child care center ((~~provided~~)) only if the child ((~~makes satisfactory progress toward full immunization~~)) provides proof of full immunization consistent with the schedule established in WAC 246-105-060 (2)(a).

(((~~7~~))) (8) "Department" means the Washington state department of health.

(((~~8~~))) (9) "Exempt" or "exemption" means a type of immunization status where a child has not been fully immunized against one or more of the vaccine-preventable diseases required by this chapter ((~~for full immunization~~)) due to medical, religious, philosophical or personal reasons. A child in this status is allowed to attend a school or child care center only by providing the required COE form.

(((~~9~~))) (10) "Full immunization" or "fully immunized" means an immunization status where a child has provided proof of acquired immunity or has been vaccinated with immunizing agents against each of the vaccine-preventable diseases listed in WAC 246-105-030 according to the national immunization guidelines described in WAC 246-105-040.

(((~~10~~))) (11) "Health care practitioner" means a physician licensed under chapter 18.71 or 18.57 RCW, a naturopath licensed under chapter 18.36A RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or an advanced registered nurse practitioner licensed under chapter 18.79 RCW.

(((~~11~~))) (12) "Health care provider" means a person licensed, certified or registered in a profession listed in RCW 18.130.040(2), if administering vaccinations is within the profession's scope of practice.

(((~~12~~))) (13) "Immunizing agent" means any vaccine or other immunologic drug licensed and approved by the United States Food and Drug Administration (FDA), or meeting World Health Organization (WHO) requirements, for immunization of persons against vaccine-preventable diseases.

(((~~13~~))) (14) "Local health officer" means the individual appointed under chapter 70.05 RCW as the health officer for the local health department, or appointed under chapter 70.08 RCW as the director of public health of a combined city-county or combined county health district.

(((~~(14)~~))) (15) "Medically verified immunization record" means a valid record that is:

(a) An electronic or written medical health record from a health care provider or facility at which the provider practices; or

(b) A document from a secure, web-based application that records and tracks immunization dates such as an immunization registry.

(16) "National immunization guidelines" means guidelines that are:

(a) Approved by the Advisory Committee on Immunization Practices (ACIP); and

(b) Published in the *Morbidity and Mortality Weekly Report (MMWR)*; and

(c) Consistent with the terms and conditions set forth in WAC 246-105-040.

(((~~(15)~~))) (17) "Out of compliance" means a type of immunization status where a child:

(a) Is not fully immunized for their age and grade against any of the vaccine-preventable diseases listed in WAC 246-105-030 according to the national immunization guidelines described in WAC 246-105-040; and

(b) Is not in conditional status for the missing required immunization; and

(c) Does not have a COE for the missing required immunization.

(18) "Parent" means, for the purposes of signature requirements in this rule:

(a) The mother, father, legal guardian, or any adult *in loco parentis* of a child less than eighteen years of age; or

(b) A person who is eighteen years of age or older and signing for themselves; or

(c) An emancipated minor.

(((~~(16)~~))) (19) "Religious membership" means membership in a religious body or church whose teachings or beliefs preclude a health care practitioner from providing medical treatment to the child.

~~(((17) "Satisfactory progress" for purposes of conditional status or an expired temporary medical exemption means the start or continuance towards full immunization status through the receipt of missing immunizations in a manner consistent with the national immunization guidelines described in WAC 246-105-040 and within the following time frames:~~

~~(a) Any missing immunizations must be received within thirty days after the first day of attendance or after a temporary medical exemption is no longer valid, unless receipt within such time is inconsistent with the guidelines.~~

~~(b) When the immunizations are part of a series with recommended intervals between doses, each additional missing immunization must be received no later than thirty days past the recommended date of administration of the next dose as established by the guidelines.~~

(((~~(18)~~))) (20) "School" means a facility, site, or campus for programs of education as defined in RCW 28A.210.070 to include preschool and kindergarten through grade twelve.

(21) "School nurse" means a registered nurse licensed under chapter 18.79 RCW, or their designee, acting as the health professional in a school.

(22) "Washington state immunization information system (WAIIS)" means a statewide, secure, web-based lifetime immunization registry that tracks medically verified immunization records for people of all ages in Washington state.

(23) "WAIIS school module" means a feature of the WAIIS that allows users to track and manage medically verified student and school-level immunization information.

AMENDATORY SECTION (Amending WSR 17-16-124, filed 7/31/17, effective 8/31/17)

WAC 246-105-040 Requirements based on national immunization guidelines. The department shall develop and distribute implementation guidelines for schools and child care centers that are consistent with the national immunization guidelines described in this section and the requirements in WAC 246-105-090.

(1) Unless otherwise stated in this section, a child must be vaccinated against, or provide documentation of immunity against, each vaccine-preventable disease listed in WAC 246-105-030 at ages and intervals according to the national immunization guidelines in the "*Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, ((~~2017~~)) 2019*"; as published in the *Morbidity and Mortality Weekly Report* (MMWR) ((~~2017;66(5):134-135~~)) 2019; 68(5):112-114.

(2) As part of the implementation guidelines, the department shall align the ages and intervals specified in the national immunization guidelines and this chapter with a corresponding grade level.

(3) In addition to the ages and intervals required by subsections (1) and (2) of this section, the following vaccine administration guidelines shall apply.

(a) Schools shall accept proof of immunization status by grade level as required by subsection (2) of this section.

(b) Schools and child care centers may accept one of the following as proof of a child's immunization status against varicella:

(((~~(a)~~))) (i) Documentation on the CIS form that the child received age appropriate varicella vaccine; or

(((~~(b)~~))) (ii) Diagnosis or verification of a history of varicella disease by a health care provider acting within ((~~his or her~~)) their scope of practice; or

(((~~(c)~~))) (iii) Diagnosis or verification of a history of herpes zoster by a health care provider acting within ((~~his or her~~)) their scope of practice; or

(((~~(d)~~))) (iv) Serologic proof of immunity against varicella; or

(((~~(e)~~))) (v) Documentation by the parent that a child has a history of varicella. This type of proof will be accepted only for certain grade levels described in the department's implementation guidelines according to WAC 246-105-090(2).

AMENDATORY SECTION (Amending WSR 14-06-037, filed 2/25/14, effective 3/28/14)

WAC 246-105-050 Required documentation of immunization status. (1) Before a child may attend a school or child care center, a parent must provide proof of immunization status using ((~~the following documentation:~~

~~(a) A department-approved CIS form signed by the parent. The CIS form must include:~~

~~(i)~~)) either a CIS or a COE form. Information provided on these forms is to be used by a school nurse, child care health consultant, or the chief administrator to determine the immunization status of a child as:

(a) Fully immunized;

(b) Out of compliance;

(c) Conditional; or

(d) Exempt.

(2) The CIS form must be either produced from the WAIIS or a department-approved hardcopy CIS form. A hardcopy CIS form not produced from the WAIIS must include completion of the following fields:

(a) Name of child;

(((~~ii~~))) (b) Birth date;

(((~~iii~~))) (c) Type of vaccine(s) administered;

(((~~iv~~))) (d) Month, day, and year of each dose of vaccine received;

(((~~v~~))) (e) A section to indicate whether a COE form accompanies the CIS form;

(((~~vi~~))) (f) If applicable, a statement signed and dated by a parent acknowledging the requirements for their child's attendance under conditional status, which includes progress towards full immunization consistent with the schedule established in WAC 246-105-060 (2)(a);

(g) A section to document serologic proof of immunity signed by a health care provider acting within ((~~his or her~~)) their scope of practice ((~~and including a copy of a lab report~~)); and

(((~~vii) Parent signature and date.~~

~~(b) If applicable,~~)) (h) A statement signed and dated by a health care provider stating that the information on the CIS is accurate; or

(i) A statement signed and dated by a school nurse, child care health consultant, or the chief administrator stating that they have confirmed the accuracy of the CIS by review of the child's medically verified immunization record, and have attached the medically verified record to the CIS. For the verification to be valid the immunization record must contain:

(i) Name of child;

(ii) Birth date;

(iii) Type(s) of vaccines administered;

(iv) Month, day, and year of each vaccine administration or if applicable serologic proof of immunity verified by a health care provider acting within their scope of practice; and

(v) The name and signature of the health care provider responsible for administering or reviewing each immunization; or

(vi) A unique stamp, logo, or other information identifying the health care provider or facility at which the provider practices.

(3) Alternately, in lieu of a CIS, a school or child care center using the WAIIS school module may accept verification by school staff that the child is fully immunized as recorded in the WAIIS.

(4) A parent who seeks an exemption to the immunization requirement must provide a department-approved COE form signed by a parent. A COE form must include:

(((~~i~~))) (a) Name of child;

(((~~ii~~))) (b) Birth date;

(((~~iii) A place~~)) (c) A field to indicate whether the parent is claiming a medical, religious, personal, or philosophical exemption. Philosophical and personal objections may not be used to exempt a child from measles, mumps, and rubella vaccine as described in WAC 246-105-055. This field must include:

(((~~A~~))) (i) A statement ((~~signed and dated by a health care practitioner~~)) from a health care practitioner that includes the practitioner's printed name, signature, and date of signature stating that ((~~he or she has~~)) they have provided the parent information about the benefits and risks of immunization to the child as a condition of obtaining a medical, religious, personal, or philosophical exemption;

(((~~B~~))) (ii) The requirement in (((~~b)(iii)(A)~~))) (4)(c)(i) of this subsection does not apply to a parent who demonstrates a religious membership under subsection (((~~b)(iii)(F)~~))) (4)(c)(vi) of this subsection;

(((~~C) A place~~)) (iii) A field to indicate any permanent or temporary medical exemption, and if temporary, the exemption expiration date for one or more vaccines which must be signed and dated by a health care practitioner;

(((~~D) A place~~)) (iv) A field to indicate any personal or philosophical exemption for one or more vaccines, except for the measles, mumps, and rubella vaccine as described in WAC 246-105-055;

(((~~E) A place~~)) (v) A field to indicate any religious exemption for one or more vaccines; and

(((~~F) A place~~)) (vi) A field to demonstrate religious membership. This must include a statement signed and dated by the parent ((~~identifying the name of the church or religious body,~~)) affirming membership in ((~~it, and affirming that the religious beliefs or~~)) a church or religious body where the teachings of the church or religious body preclude a health care practitioner from providing medical treatment to the child;

(((~~iv~~))) (d) Notice to parents that if an outbreak of vaccine-preventable disease for which the child is exempted occurs, the child may be excluded from the school or child care center for the duration of the outbreak; and

(((~~v~~))) (e) Parent signature and date.

(((~~2~~))) (5) Parents who must include a signed statement from a health care practitioner under subsection (((~~1)(b)(iii)~~))) (4)(c)(i) of this section may submit:

(a) A photocopy of the signed COE in place of the original; or

(b) Along with the COE form, a letter from the health care practitioner in ((~~place~~)) lieu of the signed statement under subsection (((~~1)(b)(iii)~~))) (4)(c)(i) of this section. The letter must:

(i) Indicate that the health care practitioner has provided the parent information about the benefits and risks of immunization to the child;

(ii) Reference the child's name; and

(iii) Be signed and dated by the health care practitioner.

(((~~3~~))) (6) If immunizations are deferred on a temporary basis for medical reasons under subsection (((~~1)(b)(iii)(C)~~))) (4)(c)(iii) of this section, the child must ((~~make satisfactory progress toward~~)) provide proof of full immunization consis-

tent with the schedule established in WAC 246-105-060 (2)(a) once the medical exemption has expired.

NEW SECTION

WAC 246-105-055 Philosophical and personal exemption for measles, mumps, and rubella vaccine prohibited. A philosophical or personal exemption may not be used to exempt a child from the measles, mumps, and rubella immunization requirement.

AMENDATORY SECTION (Amending WSR 14-06-037, filed 2/25/14, effective 3/28/14)

WAC 246-105-060 Duties of schools and child care centers. (1) Schools and child care centers shall require on or before the first day of attendance either:

(a) A CIS or COE form ((~~conforming to~~)) that documents a child's immunization status as required by WAC 246-105-050 (((~~(1)(a)~~))) for new enrollees registering for admission into preschool and kindergarten through grade twelve or a child care center as a requirement of admission((~~. Information on the CIS is used to determine if a child is fully immunized, conditional or exempt.~~

~~(b) For enrollees attending under conditional status or an expired temporary medical exemption, documentation of satisfactory progress toward full immunization.~~

~~(c) For enrollees claiming exempt status, a signed COE form indicating a medical, religious, philosophical, or personal exemption conforming to WAC 246-105-050 (1)(b)(iii) or, if applicable, WAC 246-105-050(2).~~

~~(2)~~)); and

(b) Annually for continued enrollment in a child care center.

(2) A school nurse, child care health consultant, or chief administrator shall use information from the CIS or COE form to determine the immunization status of a child as: Fully immunized, out of compliance, conditional, or exempt.

(a) For enrollees attending under conditional status or an enrollee with an expired temporary medical exemption, the following schedule for documenting proof of full immunization applies:

(i) Any doses the child is eligible to receive based on the requirements established in WAC 246-105-040 must be administered on or before the first day of attendance. Any additional missing immunizations must be received within thirty calendar days after the first day of attendance or after a temporary medical exemption is no longer valid, unless receipt within such time is inconsistent with the national immunization guidelines; or

(ii) When the immunizations are part of a series with recommended intervals between doses, each additional missing immunization must be received no later than thirty calendar days past the recommended date of administration of the next dose as established by the national immunization guidelines.

(b) Failure to document proof of full immunization consistent with the schedule established in (a) of this subsection shall result in exclusion of a child from a school or a child care center as described in WAC 246-105-080.

(3) In maintaining child immunization records, schools and child care centers shall:

(a) Keep all department-approved forms described in WAC 246-105-050 for each enrolled child attending their school or child care ((~~center~~)).

(b) Keep ((~~a~~)) or be able to produce within twenty-four hours a current list of children ((~~currently with medical, religious, philosophical, or personal exemptions~~)) who are not fully immunized. This list must be transmitted to the local health department upon request.

(c) Return the applicable department-approved CIS or ((~~applicable~~)) COE or a legible copy of such documents to the parent if the child is withdrawn from a school or child care center or transferred from the school. A school or child care center may not withhold from the parent a child's department-approved CIS or COE for any reasons, including nonpayment of school or child care center fees.

(d) Provide access to immunization records to agents of the state or local health department of each child enrolled.

(((~~3~~))) (4) In maintaining child immunization records, the chief administrator shall:

(a) Retain records for at least three years on a child who is excluded from school under this chapter. The record must include the child's name, address, and date of exclusion.

(b) Submit an immunization status report under ((~~chapter 28A.210 RCW either electronically on the internet or on a form provided~~)) RCW 28A.210.110 in a manner approved by the department. The report must be submitted to the department by November 1 of each year. If a school opens after October 1, the report is due thirty calendar days from the first day of school.

AMENDATORY SECTION (Amending WSR 14-06-037, filed 2/25/14, effective 3/28/14)

WAC 246-105-070 Duties of health care providers or organizations. A health care provider administering immunizations, or the organizations he or she works for, either public or private, shall furnish each person immunized, or ((~~his or her~~)) their parent, with a ((~~written~~)) medically verified immunization record ((~~of immunization~~)) containing information required by this chapter.

AMENDATORY SECTION (Amending WSR 09-02-003, filed 12/26/08, effective 1/26/09)

WAC 246-105-080 Criteria for excluding children from schools or child care centers. For any child excluded under subsection (1), (2), or (3) of this section, schools must use procedures consistent with chapters 180-38 and 392-380 WAC. A school or child care center shall exclude a child if one or more of the following applies:

(1) Parent(s) fail to provide ((~~a completed CIS form~~)) documentation of immunization status as required in WAC 246-105-050 on or before the child's first day of attendance.

(2) A child attending under conditional status fails to make ((~~satisfactory~~)) progress toward full immunization as required in WAC 246-105-060 (2)(a).

(3) A child has been admitted under a temporary medical exemption and the particular vaccine for which the exemption was granted is no longer contraindicated and the child fails to make ((~~satisfactory~~)) progress toward full immunization as required in WAC 246-105-060 (2)(a).

(4) A local health officer excludes a child from school or a child care center under chapter 246-110 WAC during an outbreak of a vaccine-preventable disease if the child has not been fully immunized against that disease due to:

(a) Conditional status;

(b) Out of compliance status;

(c) Medical exemption;

(((~~(c)~~))) (d) Religious exemption;

(((~~(d)~~))) (e) Philosophical exemption; or

(((~~(e)~~))) (f) Personal exemption.

AMENDATORY SECTION (Amending WSR 09-02-003, filed 12/26/08, effective 1/26/09)

WAC 246-105-090 Implementation. (1) The department shall develop and distribute implementation guidelines for schools and child care centers that:

(a) ((~~Interpret immunization requirements by grade level consistent with the ages specified in the national immunization guidelines and this chapter~~)) Meet the requirement of WAC 246-105-040(2); and

(b) Reflect national immunization guidelines for children who did not receive required immunizations prior to entry into kindergarten or first grade, and for whom a full series of immunizations is not recommended.

(2) The department may develop school implementation guidelines that waive or modify immunization requirements when a phasing-in period is warranted for a new immunization mandate, when there is limited availability of a required immunizing agent, or when new information about the safety or efficacy of an immunizing agent prompts a reevaluation of an existing vaccination requirement. Any waiver or modification must:

(a) Reflect the best available medical research as indicated by the ACIP or the state health officer recommendation;

(b) Identify a specific vaccine-preventable disease or immunizing agent;

(c) Identify a specific cohort of children by age or grade level;

(d) Be limited in duration; and

(e) Be approved by the board.

WSR 19-14-103
PROPOSED RULES
STATE BOARD OF HEALTH

[Filed July 2, 2019, 9:53 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-22-104.

Title of Rule and Other Identifying Information: Chapter 246-650 WAC, Newborn screening, the Washington state board of health (board) is proposing to amend the newborn screening (NBS) rules to add Pompe disease and Mucopolysaccharidosis type I (MPS I) to the list of mandatory conditions for newborn screening conducted by the department of health; create a new section outlining critical congenital heart disease screening requirements to align with RCW 70.83.090; and to improve clarity and usability of the rule.

Hearing Location(s): On August 14, 2019, at 1:30 p.m., at the John A. Cherberg Building, Senate Hearing Room 4, 304 15th Avenue S.W., Olympia, WA 98504.

Date of Intended Adoption: August 14, 2019.

Submit Written Comments to: Alexandra Montano, P.O. Box 47990, Olympia, WA 98504-7990, email https://fortress.wa.gov/doh/policyreview, fax 360-236-4088, by July 24, 2019.

Assistance for Persons with Disabilities: Contact Alexandra Montano, phone 360-236-4106, TTY 360-833-6388 or 711, email alexandra.montano@sboh.wa.gov, by July 24, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the proposal is to amend chapter 246-650 WAC to add Pompe disease and MPS I to the panel of disorders that every newborn must be tested for unless the parents or guardian object on the grounds that such tests conflict with their religious tenets and practices. Pompe disease was added to the United States Department of Health and Human Services Recommended Uniform Screening Panel (RUSP) in 2015 and MPS I was added to the RUSP in 2016. Pompe disease and MPS I are both severe conditions that can result in significant physical or mental morbidity or death if not detected and treated early. Early diagnosis of these conditions through newborn screening is essential to both save the lives and improve the quality of life of affected infants and their families.

In addition, the proposed rule creates a new section outlining critical congenital heart disease screening requirements as described in RCW 70.83.090, and improves the clarity and usability of the rule by ensuring that definitions are complete and up-to-date and consistent terms are used throughout the rule.

Reasons Supporting Proposal: Population-based NBS is the best way to ensure that newborns with Pompe disease and MPS I are identified and can receive treatment before the condition causes irreversible damage or death. In order for universal screening of these conditions to occur in Washington, chapter 246-650 WAC must be amended to include these conditions. Aligning the rule with RCW 70.83.090 to address requirements for critical congenital heart disease screening will also provide clarity and consistency for stakeholders.

Statutory Authority for Adoption: RCW 70.83.050, 70.83.090.

Statute Being Implemented: RCW 70.83.020.

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

Name of Proponent: Washington state board of health, governmental.

Name of Agency Personnel Responsible for Drafting: Alexandra Montano, 101 Israel Road S.E., Tumwater, WA 98504-7990, 360-236-4106; Implementation and Enforcement: John Thompson, 1610 N.E. 150th Street, Shoreline, WA 98155, 206-418-5531.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by

contacting Alexandra Montano, P.O. Box 47990, Olympia, WA 98504-7990, phone 360-236-4106, fax 360-236-4088, TTY 360-833-6388 or 711, email alexandra.montano @sboh.wa.gov.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The cost threshold for the industry of direct health and medical insurance carriers (NAICS Code: 524114) is $79,165.

(Annual Payroll/Total establishments) * (0.01) = (593,741 * 1,000)/75) * (0.01) = $79,165.

Half of births in Washington are covered by medicaid and it is assumed that the other half are covered by private insurance. The total cost of the rule to private industry would be $471,833.25.

Total cost of the rule: $10.50 fee increase per baby * 89,873 estimated births = $943,666.50.

$943,666.5/2 = $471,833.25 (half of the births are medicaid, half are private insurance).

We do not have a way of knowing how many babies will be covered by each of the seventy-five different establishments so we calculated an average cost per establishment of $6,291.11.

$471,833.25 (total cost to private industry)/75 (total establishments) = $6,291.11.

Therefore, the average cost of the rule per establishment does not exceed the average cost threshold for the industry and does not require a small business economic impact statement.

July 2, 2019
Michelle A. Davis
Executive Director

AMENDATORY SECTION (Amending WSR 03-24-026, filed 11/24/03, effective 12/25/03)

WAC 246-650-001 Purpose. The purpose of this chapter is to establish board rules to detect, in newborns, congenital disorders leading to developmental ((~~impairment~~)) or physical disabilities as required by RCW 70.83.050 and to provide protections for the confidentiality of information and human biological specimens submitted pursuant to these requirements.

AMENDATORY SECTION (Amending WSR 18-01-024, filed 12/8/17, effective 3/1/18)

WAC 246-650-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

((~~For the purposes of this chapter:~~))

(1) "Amino acid disorders" means ((~~disorders of metabolism characterized by the body's inability to correctly process amino acids or the inability to detoxify the ammonia released during the breakdown of amino acids. The accumulation of amino acids or their by-products may cause severe complications including intellectual disability, coma, seizures, and possibly death. For the purpose of this chapter amino acid disorders include:~~)) argininosuccinic acidemia (ASA), citrullinemia type I (CIT), homocystinuria (HCY), maple syrup urine disease (MSUD), phenylketonuria (PKU), and tyrosinemia type I (TYR I), which may cause severe complications including intellectual disability, coma, seizures, and possibly death.

(2) "Board" means the Washington state board of health.

(3) "Biotinidase deficiency" means a deficiency of an enzyme (biotinidase) that facilitates the body's recycling of biotin. The result is biotin deficiency, which if undetected and untreated, may result in severe neurological damage or death.

(4) "Congenital adrenal hyperplasia" means a severe disorder of adrenal steroid metabolism which may result in death of an infant during the neonatal period if undetected and untreated.

(5) "Congenital hypothyroidism" means a disorder of thyroid function during the neonatal period causing impaired mental functioning if undetected and untreated.

(6) "Critical congenital heart disease" means an abnormality in the structure or function of the heart that exists at birth, causes severe, life-threatening symptoms, and requires medical intervention within the first year of life.

(7) "Cystic fibrosis" means a life-shortening ((~~disease~~)) disorder caused by mutations in the gene encoding the cystic fibrosis transmembrane conductance regulator (CFTR), a transmembrane protein involved in ion transport. Affected individuals suffer from chronic, progressive pulmonary disease and nutritional deficits. Early detection and enrollment in a comprehensive care system provides improved outcomes and avoids the significant nutritional and growth deficits that are evident when diagnosed later.

(((~~7~~))) (8) "Department" means the Washington state department of health.

(((~~8~~))) (9) "Fatty acid oxidation disorders" means ((~~disorders of metabolism characterized by the inability to efficiently use fat to make energy. When the body needs extra energy, such as during prolonged fasting or acute illness, these disorders can lead to hypoglycemia and metabolic crises resulting in serious damage affecting the brain, liver, heart, eyes, muscle, and possibly death. For the purpose of this chapter fatty acid oxidation disorders include:~~)) carnitine uptake defect (CUD), long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHADD), medium-chain acyl-CoA dehydrogenase deficiency (MCADD), trifunctional protein deficiency (TFP), and very long-chain acyl-CoA dehydrogenase deficiency (VLCADD). These disorders can lead to hypoglycemia and metabolic crises resulting in serious damage affecting the brain, liver, heart, eyes, muscle, and possibly death.

(((~~9~~))) (10) "Galactosemia" means a deficiency of enzymes that help the body convert the simple sugar galactose into glucose resulting in a buildup of galactose and galactose-1-PO_4 in the blood. If undetected and untreated, accumulated galactose-1-PO_4 may cause significant tissue and organ damage often leading to sepsis and death.

(((~~10~~))) (11) "Hemoglobinopathies" means a group of hereditary blood disorders caused by genetic alteration of hemoglobin which results in characteristic clinical and laboratory abnormalities and which leads to developmental impairment or physical disabilities.

(((~~(11) "Organic acid disorders" means disorders of metabolism characterized by the accumulation of nonamino organic acids and toxic intermediates. This may lead to metabolic crisis with ketoacidosis, hyperammonemia and hypoglycemia resulting in severe neurological and physical damage and possibly death. For the purpose of this chapter organic acid disorders include: 3-OH 3-CH3 glutaric aciduria (HMG), beta-ketothiolase deficiency (BKT), glutaric acidemia type I (GA 1), isovaleric acidemia (IVA), methylmalonic acidemia (CblA,B), methylmalonic acidemia (*mutase deficiency*) (MUT), multiple carboxylase deficiency (MCD), and propionic acidemia (PROP).~~)))

(12) "Newborn" means an infant born in any setting in the state of Washington.

(13) "Newborn screening specimen/information form" means ((~~the information~~)) a form provided by the department ((~~including~~)) for collecting a newborn's dried blood spots and information used to screen for congenital disorders under this chapter. This includes the filter paper portion and associated dried blood spots. ((~~A specimen/information form containing patient information is "health care information" as used in chapter 70.02 RCW.~~))

(14) "Mucopolysaccharidosis I (MPS-I)" means a multisystem disorder caused by mutations in the alpha-L-iduronidase gene in which a lysosomal enzyme is deficient, leading to accumulation of mucopolysaccharides (a type of carbohydrate) and other metabolites. This includes Hurler, Hurler-Scheie, and Scheie syndromes.

(15) "Organic acid disorders" means 3-OH 3-CH3 glutaric aciduria (HMG), beta-ketothiolase deficiency (BKT), glutaric acidemia type I (GA 1), isovaleric acidemia (IVA), methylmalonic acidemia (CblA,B), methylmalonic acidemia (mutase deficiency) (MUT), multiple carboxylase deficiency (MCD), and propionic acidemia (PROP). These disorders can lead to metabolic crises resulting in severe nerve damage, physical damage, and possibly death.

(16) "Pompe disease" means a neuromuscular disorder caused by mutations in the acid glucosidase gene which result in reduced or absent activity of the acid alpha glucosidase enzyme.

(17) "Significant screening test result" means a laboratory test result indicating a suspicion of abnormality and requiring ((~~further~~)) diagnostic evaluation of the involved infant for ((~~the~~)) a specific congenital disorder.

(((~~(15)~~))) (18) "Severe combined immunodeficiency (SCID)" means a group of congenital disorders characterized by profound deficiencies in T- and B- lymphocyte function. This results in very low or absent production of the body's primary infection fighting processes that, if left untreated, results in severe recurrent, and often life-threatening infections within the first year of life.

(((~~(16)~~))) (19) "X-linked adrenoleukodystrophy (X-ALD)" means a peroxisomal disorder caused by mutations in the ABCD1 gene located on the X chromosome. If untreated this can lead to adrenocortical deficiency, damage to the nerve cells of the brain, paralysis of the lower limbs, mental decline, disability, or death.

AMENDATORY SECTION (Amending WSR 18-01-024, filed 12/8/17, effective 3/1/18)

WAC 246-650-020 Performance of screening tests. (1) Hospitals and other providers of birth and delivery services or neonatal care to infants shall:

(a) Inform parents or ((~~responsible parties~~)) guardians, by providing a departmental information pamphlet or by other means, of:

(i) The purpose of screening newborns for congenital disorders;

(ii) Disorders of concern as listed in WAC 246-650-020(2);

(iii) The requirement for newborn screening;

(iv) The legal right of parents or ((~~responsible parties~~)) guardians to refuse testing because of religious tenets or practices as specified in RCW 70.83.020; and

(v) The specimen storage, retention and access requirements specified in WAC 246-650-050.

(b) Obtain a blood specimen for laboratory testing as specified by the department from each newborn no later than forty-eight hours following birth.

(c) Use department-approved newborn screening specimen/information forms and directions for obtaining specimens.

(d) Enter all identifying and related information required on the newborn screening specimen/information form following directions of the department.

(e) In the event a parent or ((~~responsible party~~)) guardian refuses to allow newborn screening, obtain signatures from parents or ((~~responsible parties~~)) guardians on the ((~~department~~)) newborn screening specimen/information form.

(f) Forward the newborn screening specimen/information form with dried blood spots or signed refusal to the Washington state public health laboratory so that it will be received no later than seventy-two hours following collection of the specimen, excluding any day that the state laboratory is closed.

(2) Upon receipt of specimens, the department shall:

(a) Record the time and date of receipt;

(b) Perform appropriate screening tests for:

(i) ((~~Biotinidase deficiency;~~

~~(ii) Congenital hypothyroidism;~~

~~(iii) Congenital adrenal hyperplasia;~~

~~(iv) Galactosemia;~~

~~(v) Hemoglobinopathies;~~

~~(vi) Cystic fibrosis;~~

~~(vii) The amino acid disorders: Argininosuccinic acidemia (ASA), citrullinemia (CIT), homocystinuria, maple syrup urine disease (MSUD), phenylketonuria (PKU), and tyrosinemia type I (TYR 1);~~

~~(viii) The fatty acid oxidation disorders: Carnitine uptake defect (CUD), long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHADD), medium-chain acyl-coA dehydrogenase deficiency (MCADD), trifunctional protein deficiency (TFP), and very long-chain acyl-CoA dehydrogenase deficiency (VLCADD);~~

~~(ix) The organic acid disorders: 3-OH 3-CH3 glutaric aciduria (HMG), beta-ketothiolase deficiency (BKT), glutaric acidemia type I (GA 1), isovaleric acidemia (IVA), methylmalonic acidemia (CblA,B), methylmalonic acidemia~~

(*mutase deficiency*) (MUT), multiple carboxylase deficiency (MCD), propionic acidemia (PROP);

(x) Severe combined immunodeficiency (SCID);

(xi) X-linked adrenoleukodystrophy (X-ALD))) Amino acid disorders;

(ii) Biotinidase deficiency;

(iii) Congenital hypothyroidism;

(iv) Congenital adrenal hyperplasia;

(v) Cystic fibrosis;

(vi) Fatty acid oxidation disorders;

(vii) Galactosemia;

(viii) Hemoglobinopathies;

(ix) Mucopolysaccharidosis type I (MPS-I);

(x) Organic acid disorders;

(xi) Pompe disease;

(xii) Severe combined immunodeficiency (SCID);

(xiii) X-linked adrenoleukodystrophy (X-ALD).

(c) Report significant screening test results to the infant's attending ((physician or family)) health care provider or parent or guardian if an attending ((physician)) health care provider cannot be identified; and

(d) Offer diagnostic and treatment resources ((of the department)) to ((physicians)) health care providers attending infants with ((presumptive positive)) significant screening test((s)) results within limits determined by the department.

(3) Once the department notifies the attending health care provider of significant screening test results, the attending health care provider shall notify the department of the date upon which the results were disclosed to the parent or guardian of the infant. This requirement expires January 1, 2020.

NEW SECTION

WAC 246-650-035 Screening for critical congenital heart disease. (1) Prior to a hospital discharge of a newborn, the hospital shall ensure that:

(a) A licensed health care provider perform critical congenital heart disease screening on the newborn using pulse oximetry according to recommended American Academy of Pediatrics guidelines;

(b) Record the results of the critical congenital heart disease screening test in the newborn's medical record; and

(c) If the screening test indicates a suspicion of abnormality, refer the newborn for appropriate care and report the test results to the newborn's attending health care provider and parent, parents, or guardian.

(2)(a) Except as provided in (b) of this subsection, a health care provider attending a birth outside of a hospital shall, between twenty-four and forty-eight hours after the birth of the newborn:

(i) Perform critical congenital heart disease screening on the newborn using pulse oximetry according to recommended American Academy of Pediatrics guidelines;

(ii) Record the results of the critical congenital heart disease screening test in the newborn's medical record; and

(iii) If the screening test indicates a suspicion of abnormality, refer the newborn for appropriate care and report the test results to the newborn's attending health care provider and parents or guardians.

(b) If the health care provider does not perform the test required in (a) of this subsection because he or she does not possess the proper equipment, the health care provider shall notify the parents or guardians in writing that the health care provider was unable to perform the test and that the newborn should be tested by another health care provider no sooner than twenty-four hours after the birth, but no later than forty-eight hours after the birth.

(3) A health care provider may not test a newborn as required by this section if the parents or guardians object to the test based on religious beliefs.

AMENDATORY SECTION (Amending WSR 14-21-017, filed 10/2/14, effective 11/2/14)

WAC 246-650-040 Reports to the board and the public. (1) The department shall report to the board annually the following information concerning tests conducted under ((this section)) WAC 246-650-020:

(a) The costs of tests as charged by the department;

(b) The results of each category of tests, by county of birth and racial or ethnic group, as reported on the newborn screening specimen/information form ((and, if available, birth certificates)); and

(c) Follow-up procedures and the results of such follow-up procedures.

(2) The department shall compile an annual report for the public that includes:

(a) The compliance rate of each hospital in meeting the deadlines established under RCW 70.83.020 for newborn screenings; and

(b) The performance rate of each individual hospital((;

(c) The time taken by health care providers to notify parents and guardians after being notified by the department about infant screening tests that indicate a suspicion of abnormality that requires further diagnostic evaluation. Notification times will be summarized and reported in increments of days)).

(3) The reports must be made available in a format that does not disclose the identifying information related to any infant, parent or guardian, or health care provider.

(4) The report must be posted in an accessible location on the department of health's web site.

(((5) Subsections (2) through (4) of this section expire January 1, 2020.))

AMENDATORY SECTION (Amending WSR 03-24-026, filed 11/24/03, effective 12/25/03)

WAC 246-650-050 Privacy and security of newborn screening specimen/information forms. The newborn screening specimen/information form submitted to the department pursuant to WAC 246-650-020 becomes the property of the state of Washington upon receipt by the Washington state public health laboratory. The department shall protect the privacy of newborns and their families and assure that all specimen/information forms submitted for screening are protected from inappropriate use or access. A newborn specimen/information form contains health care information that is confidential under chapter 70.02 RCW.

(1) Storage: The newborn screening specimen/information forms shall be kept at ambient temperature in secured storage to preserve their confidentiality and prevent access by unauthorized persons.

(2) Retention/destruction: The newborn screening specimen/information form shall be retained until the child is twenty-one years old in accordance with the requirements for hospitals specified in RCW 70.41.190. After this time the ((~~form will be destroyed~~)) department shall destroy the form.

EXCEPTION FOR PARENTAL REQUEST: Upon request of a parent or guardian (or a patient who is over the age of eighteen years), the department ((~~will~~)) shall destroy the newborn screening specimen/information form only after all required screening tests have been performed and if the patient's screening/clinical status related to these tests is not in question.

(3) Access: Access to stored newborn screening specimen/information forms ((~~shall~~)) must be restricted to department employees and those contractors or others approved by the department as necessary to meet specific program needs. Access is contingent upon compliance with all applicable federal and state laws, regulations, and policies safeguarding the privacy and confidentiality of medical information. The department shall assure that those granted access understand the confidentiality requirements and have a signed confidentiality agreement on file.

(4) Release: Dried blood spot samples and specimen information may only be released when required by state or federal law or under the following conditions:

(a) A sample from a specimen and copies of associated identifying information (patient information and testing results, if requested) may be released to:

(i) A health care provider at the request of the patient or ((~~their~~)) his or her legal representative after completing and signing a written request form approved by the department. The release form must be provided to the director of newborn screening before the request will be fulfilled.

(ii) A researcher with the written, informed consent of the patient or ((~~their~~)) the patient's legal representative as part of a research project that has been reviewed and approved by the ((~~DOH/DSHS human subjects research~~)) Washington state institutional review board and the secretary or designee of the department ((~~of health~~)).

(iii) A named person in a legally executed subpoena following review and approval of the state attorney general.

(iv) A person to whom release is mandated by order of a court of competent jurisdiction.

(b) Anonymous samples may be released if the department determines that the intended use has significant potential health benefit and that each of the following criteria have been met:

(i) The investigation design is adequate to assure anonymity will be preserved.

(ii) All newborn screening tests have been completed and the status of the infant is resolved.

(iii) At least one fully adequate spot will remain after the anonymous sample has been taken.

(iv) Sufficient resources (personnel) are available for extracting the samples.

(v) The ((~~DOH/DSHS human subjects research~~)) Washington state institutional review board has reviewed and approved the investigation. This requirement may be waived by the department for a very small (i.e., less than 100 sample) pilot study where the intent is to evaluate a testing tool, as opposed to an evaluation where the intent is to measure some characteristic of a population.

(5) Notification: The department shall notify parents or guardians of the specimen storage, retention/destruction and access requirements through the department's newborn screening informational pamphlet.

AMENDATORY SECTION (Amending WSR 99-20-036, filed 9/29/99, effective 10/30/99)

WAC 246-650-990 Screening charge. The department has authority under RCW 43.20B.020 to require a reasonable charge from parents, guardians, or responsible parties for the costs of newborn screening. The charge is to be collected through the facility where the specimen was obtained.

AMENDATORY SECTION (Amending WSR 05-20-108, filed 10/5/05, effective 11/5/05)

WAC 246-650-991 Specialty clinic support fee. ((~~(1)~~)) The department has the authority under RCW ((~~70.83.040~~)) 70.83.023 to collect ((~~a~~)) an eight dollar and forty cent fee for each infant screened to fund specialty clinics that provide treatment services for ((~~hemoglobin diseases, phenylketonuria,~~)) congenital ((~~adrenal hyperplasia, congenital hypothyroidism and other~~)) disorders defined by the state board of health under RCW 70.83.020, and may also be used for purposes of funding activities in subsection (2) of this section. This fee is to be collected in conjunction with the screening charge described in WAC 246-650-990.

(((~~(2) The specialty clinic support fee is $3.50. It is to be collected in conjunction with the screening charge from the parents or other responsible party through the facility where the screening specimen is obtained.~~

~~(3) However, effective through June 30, 2007, the department will collect an additional $3.10 to fund specialty clinics that provide treatment services for other disorders defined by the board under RCW 70.83.020.~~))

WSR 19-14-104
PROPOSED RULES
TRANSPORTATION COMMISSION
[Filed July 2, 2019, 10:58 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-10-032.

Title of Rule and Other Identifying Information: State ferries and toll bridges, WAC 468-300-010, 468-300-020, and 468-300-040.

To meet legislative budget requirements, the transportation commission is proposing adjustments to ferry fares in October 2019 and May 2020. Proposed revisions to WAC 468-300-010, 468-300-020, and 468-300-040 increase pas-

senger fares and vehicle fares effective on October 1, 2019; and a second increase effective on May 1, 2020. The commission also proposes a change to the reservation no-show fee to discourage abuse of the reservation system.

Hearing Location(s): On Tuesday, August 6, 2019, at 10:00 a.m., at the Puget Sound Regional Council, Board Room, 1011 Western Avenue, Seattle, WA 98104.

Date of Intended Adoption: Tuesday, August 6, 2019.

Submit Written Comments to: Reema Griffith, Executive Director, Transportation Commission, 2404 Chandler Court S.W., Suite 270, Olympia, WA 98501, email griffir@wstc.wa.gov, fax 360-705-6802, by July 29, 2019.

Assistance for Persons with Disabilities: Contact transportation commission office, phone 360-705-7070, fax 360-705-6802, TTY 711 connect to 360-705-7070, email transc@wstc.wa.gov, by July 31, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this rule is to: (i) Increase ferry fares; (ii) modify certain fare categories; and (iii) per legislative direction, increase a capital surcharge to help fund new ferry construction, all within the specified WAC. The revisions follow the annual review of Washington state ferries' (WSF) fares and policies.

The anticipated effects of this proposal: General ferry fares will increase; some fare categories will be modified; and a legislatively directed capital surcharge will be increased to help fund new ferry construction.

Reasons Supporting Proposal: The proposed fare changes are to meet requirements in state law, including adjustments to ferry fares to meet the fare revenue target established in the two year transportation budget and to improve ferry operations.

Statutory Authority for Adoption: RCW 47.56.030 and 47.60.315.

Statute Being Implemented: RCW 47.56.030 and 47.60.315.

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

Name of Proponent: Washington state department of transportation, ferries division, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Raymond G. Deardorf, 2901 Third Avenue, Suite 500, Seattle, WA 98121, 206-515-3491.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. WSF is required to generate farebox revenue from the proposed fare increase which will meet the biennial budget requirement for operating revenue, which is estimated to be approximately $9.7 million more in operating revenue generated for the 2019-2021 biennium. WSF also is required to generate additional revenue for construction of a new vessel. The proposed capital surcharge will generate approximately $4.9 million more than existing fares would generate for the 2019-2021 biennium.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules set or adjust fees under the authority of RCW 19.02.075 or that set or adjust fees or rates pursuant to legislative standards, including fees set or adjusted under the authority of RCW 19.80.045.

July 2, 2019
Reema Griffith
Executive Director

AMENDATORY SECTION (Amending WSR 17-18-018, filed 8/25/17, effective 9/25/17)

WAC 468-300-010 Ferry passenger tolls.

EFFECTIVE 03:00 A.M. October 1, ((~~2017~~)) 2019

ROUTES	Full Fare[9]	Senior/ Disabled, Youth[9]	Multiride Media 20 Rides[1, 9]	Monthly Pass[5, 9]	Bicycle Surcharge[2]
Via Auto Ferry *Fauntleroy-Southworth	((~~6.45~~)) 6.75	((~~3.20~~)) 3.35	((~~52.10~~)) 54.50	((~~83.40~~)) 87.20	1.00
*Seattle-Bremerton *Seattle-Bainbridge Island *Edmonds-Kingston	((~~8.35~~)) 8.65	((~~4.15~~)) 4.30	((~~67.30~~)) 69.70	((~~107.70~~)) 111.55	1.00
Port Townsend-Coupeville	((~~3.35~~)) 3.50	((~~1.65~~)) 1.75	((~~54.60~~)) 57.00	((~~87.40~~)) 91.20	0.50
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~5.45~~)) 5.65	((~~2.70~~)) 2.80	((~~44.10~~)) 45.70	((~~70.60~~)) 73.15	1.00
*Mukilteo-Clinton	((~~5.05~~)) 5.20	((~~2.50~~)) 2.60	((~~40.90~~)) 42.10	((~~65.45~~)) 67.40	1.00
*Anacortes to Lopez, Shaw, Orcas or Friday Harbor	((~~13.50~~)) 14.00	((~~6.70~~)) 7.00	((~~88.65~~)) 91.90	N/A	2.00[6]
Between Lopez, Shaw, Orcas and Friday Harbor[4]	N/C	N/C	N/C	N/A	N/C
Anacortes to Sidney and Sidney to all destinations	((~~19.85~~)) 20.65	((~~9.85~~)) 10.30	N/A	N/A	4.00[7]
From Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~12.40~~)) 12.90	((~~6.10~~)) 6.40	N/A	N/A	2.00[8]

ROUTES	Full Fare[9]	Senior/ Disabled, Youth[9]	Multiride Media 20 Rides[1, 9]	Monthly Pass[5, 9]	Bicycle Surcharge[2]
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[3]	((~~24.55~~)) 25.55	((~~11.90~~)) 12.55	N/A	N/A	4.00[7]

All fares rounded to the next multiple of $0.05.

*These routes operate as a one-point toll collection system.

[1]MULTIRIDE MEDIA - Shall be valid only for 90 days from date of purchase after which time the tickets shall not be accepted for passage. Remaining value will not be eligible for refund or exchange. There shall be no commercial resale of this fare media. For mail order deliveries, WSF may add additional days to allow for delivery times.

[2]BICYCLE SURCHARGE - Is an addition to the appropriate passenger fare. Customers using multiride media and monthly passes are exempt from the bicycle surcharge. On all routes except Anacortes/San Juan Island/Sidney, B.C., customers paying with the ePurse or the ORCA card are exempt from the bicycle surcharge. For the purpose of WSF fare determination, the bicycle fare category shall include both bicycles as defined by RCW 46.04.071 and electric-assisted bicycles as defined in RCW 46.04.169. Bicycles towing a kayak or canoe are to be charged the motorcycle/driver (stowage) rate in WAC 468-300-020. This rate includes the fare for the walk on passenger with the bicycle, and the kayak or canoe being towed by the bicycle. This requirement shall not apply to interisland travel in the San Juan Islands. All other bicycles towing trailers are charged the applicable bicycle surcharge.

[3]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the Islands served.

[4]INTER-ISLAND FARES - Passenger fares included in Anacortes tolls.

[5]PASSES - Passenger passes are available for all routes except Anacortes/San Juan Island/Sidney. Passes are valid for the period printed on the pass and will be presented to Washington state ferries staff or scanned through an automated turnstile whenever a passenger fare is collected. This pass is based on 16 days of passenger travel with a 20% discount. A $1.00 retail/shipping and handling fee will be added to the price of the pass.

A combination ferry-transit pass may be available for a particular route when determined by Washington state ferries and a local public transit agency to be a viable fare instrument. The WSF portion of the fare is based on 16 days of passenger travel per month at a 20% discount.

The monthly pass is valid for a maximum of 31 round trips per month, is nontransferable, is nonreproducible, and is intended for a single user. Monthly passes purchased through the regional SmartCard program are also nontransferable and intended for a single user, but allow for unlimited usage.

[6]BICYCLE SURCHARGE - This becomes $4.00 during peak season (May 1 through September 30).

[7]BICYCLE SURCHARGE - This becomes $6.00 during peak season.

[8]BICYCLE SURCHARGE - This becomes $3.00 during peak season.

[9]CAPITAL SURCHARGE - Included is a $0.25 capital surcharge on each single passenger fare collected. On all multiride cards except for Port Townsend/Coupeville, there is included a capital surcharge of $2.50. For Port Townsend/Coupeville, the included capital surcharge is $5.00 on multiride cards. On all monthly passes except Port Townsend/Coupeville, there is included a $4.00 capital surcharge. For Port Townsend/Coupeville, the included capital surcharge is $8.00 on monthly passes.

CHILDREN/YOUTH - Children under six years of age will be carried free when accompanied by parent or guardian. Children/youths six through eighteen years of age will be charged the youth fare, which will be 50% of full fare rounded to the next multiple of $0.05.

SENIOR CITIZENS - Passengers age 65 and over, with proper identification establishing proof of age, may travel at half-fare passenger tolls on any route where passenger fares are collected.

((~~PERSONS OF DISABILITY - Any individual who, by reason of illness, injury, congenital malfunction, or other incapacity or disability is unable without special facilities or special planning or design to utilize ferry system services~~)) PEOPLE WITH DISABILITIES - Any person who has a physical or mental impairment that substantially limits one or more major life activity, upon presentation of a WSF Disability Travel Permit, Regional Reduced Fare Permit, or other identification which establishes a disability may travel at half-fare passenger tolls on any route where passenger fares are collected. In addition, ((~~those persons~~)) people with disabilities who require attendant care while traveling on the ferries, and are so certified by their physician, may obtain an endorsement on their WSF Disability Travel Permit and such endorsement shall allow the attendant to travel free as a passenger.

BUS PASSENGERS - Passengers traveling on public transit buses pay the applicable fare. Passengers traveling in private or commercial buses will be charged the half-fare rate.

MEDICARE CARD HOLDERS - Any person holding a medicare card duly issued to that person pursuant to Title II or Title XVIII of the Social Security Act may travel at half-fare passenger tolls on any route upon presentation of a WSF Disability Travel Permit or a Regional Reduced Fare Permit at time of travel.

IN-NEED ORGANIZATIONS - For qualified organizations serving in-need clients by providing tickets for transportation on WSF at no cost to clients, program would offer a monthly discount to approximate appropriate multiride media discount rates. Appointing bodies (those that appoint Ferry Advisory Committees) will nominate to the Washington State Transportation Commission those organizations that meet the criteria of the program. The Commission will review such nominations and certify those organizations that qualify. The following criteria will be used for nominating and certifying in-need organizations: Nongovernmental and not-for-profit organizations whose primary purpose is one or more of the following: Help clients with medical issues; provide clients with low-income social services; help clients suffering from domestic violence; provide clients with employment-seeking services; and/or help clients with Social Security. Travel will be initially charged based on full fare and billed monthly. The credits will be approximately based on the discount rates offered to multiride media users applicable on the date of travel.

PROMOTIONAL TOLLS - A promotional rate may be established at the discretion of the WSF Assistant Secretary, Executive Director for a specific discount in order to enhance total revenue and effective only at designated times on designated routes. A promotional fare product may also be estab-

lished to support tourism or other special events. The promotional fare or product may be bundled and sold as part of a multiparty promotional program.

Special passenger fare rate(s) may be established for a pilot program in conjunction with the Central Puget Sound Regional Fare Integration project on ferry route(s) serving King, Pierce, Snohomish and Kitsap counties. The rate(s) may be established at the discretion of the WSF Assistant Secretary, Executive Director for a specific discount not to exceed fifty percent of full fare.

SCHOOL GROUPS - Passengers traveling in authorized school groups, including home-school groups, will be charged a flat rate of $1 per walk-on group or per vehicle of students and/or advisors and staff. All school groups require a letter of authorization and prior notification. In the case of home-school groups, in addition to prior notification, a copy of the filed Declaration of Intent (as outlined in RCW 28A.200.010) shall be submitted to the tollbooth at the time of travel. Notification shall be made no less than 72 hours before the scheduled departure and will include the expected number of school-age children and adults that will be traveling to ensure WSF can satisfy U.S. Coast Guard lifesaving equipment requirements. Failure to provide adequate notification may result in delayed travel. Vehicles and drivers will be charged the fare applicable to vehicle size. The special school rate is $2 on routes where one-point toll systems are in effect.

BUNDLED SINGLE FARE BOOKS - WSF may bundle single fare types into multiride media as a customer convenience. Remaining value will not be eligible for refund or exchange. For mail order deliveries, WSF may add additional days for delivery times.

FIRE DEPARTMENT AND FIRE DISTRICT FARE CONSIDERATION - At the discretion of the WSF Assistant Secretary, WSF may authorize no-fare or discounted fare passage on scheduled and/or special ferry sailings for fire departments and fire districts that provide contracted fire protection services for WSF ferry terminals and/or other WSF facilities within their jurisdiction. Such passage shall be considered full and complete consideration for such fire protection services, in lieu of annual payments for such services, to be so noted in such fire protection agreements. The scope of such authorization includes designated fire department and fire district vehicles (see below), drivers and passengers en route to and from an emergency call, on ferry routes with a WSF terminal and/or other WSF facility served by a fire department or fire district pursuant to a WSF fire protection service agreement. Authorized vehicles may include public fire department and fire district medical aid units, fire trucks, incident command and/or other vehicles dispatched to and returning from an emergency call.

GROUP OR VOLUME SALES - In order to increase total revenues, WSF may develop full fare or discounted customer packages or bundle single fare types into multiride media or offer passes for high volume or group users. In pricing these packages, WSF will have discretion to set appropriate volume discounts based on a case-by-case basis.

SPECIAL EVENTS - In order to increase total revenues, WSF may develop, create or participate in special events that may include, but not be limited to, contributing or packaging discounted fares in exchange for the opportunity to participate in the income generated by the event.

LOW-INCOME FARE PILOT - Starting no earlier than January 1, 2020, special passenger fare rate(s) may be established for a pilot program offering a low-income fare on any ferry route for riders made eligible through an existing transit agency's low-income fare program. Enactment of this program is dependent upon legislative funding for the pilot project. If funded, Washington State Ferries' Assistant Secretary shall submit a proposal to carry out this pilot program and the Washington State Transportation Commission must approve both the program and the fare schedule before it is implemented. Once implemented, WSF shall provide, at a minimum, updates to the Commission every six months on the pilot. The pilot will conclude no longer than three years from its implementation.

GOOD TO GO! PILOT - Special ferry toll rate(s) may be established for a pilot program of Good to Go! or similar fare collection infrastructure, technology, or ORCA replacement system on any ferry route. Washington State Ferries Assistant Secretary shall design the program and submit a proposed program and fare schedule to the Washington State Transportation Commission. The Commission shall review, modify and approve the proposed fare schedule and fare policies before it is implemented. Once implemented, WSF shall provide, at a minimum, updates to the Commission every six months on the pilot. The pilot will conclude no longer than three years from its implementation.

EFFECTIVE 03:00 A.M. ((~~October 1, 2018~~)) May 1, 2020

ROUTES	Full Fare[8]	Senior/ Disabled, Youth[8]	Multiride Media 20 Rides[1, 8]	Monthly Pass[5, 8]	Bicycle Surcharge[2]
Via Auto Ferry *Fauntleroy-Southworth	((~~6.65~~)) 7.10	((~~3.30~~)) 3.55	((~~53.70~~)) 57.80	((~~85.95~~)) 92.50	1.00
*Seattle-Bremerton *Seattle-Bainbridge Island *Edmonds-Kingston	((~~8.50~~)) 9.05	((~~4.25~~)) 4.50	((~~68.50~~)) 73.40	((~~109.60~~)) 117.45	1.00
Port Townsend-Coupeville	((~~3.45~~)) 3.80	((~~1.70~~)) 1.80	((~~56.20~~)) 62.80	((~~89.95~~)) 100.50	0.50
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~5.55~~)) 5.95	((~~2.75~~)) 2.95	((~~44.90~~)) 48.60	((~~71.85~~)) 77.80	1.00
*Mukilteo-Clinton	((~~5.10~~)) 5.55	((~~2.55~~)) 2.75	((~~41.30~~)) 45.40	((~~66.10~~)) 72.65	1.00
*Anacortes to Lopez, Shaw, Orcas or Friday Harbor	((~~13.75~~)) 14.50	((~~6.85~~)) 7.25	((~~90.25~~)) 96.00	N/A	2.00[6]
Between Lopez, Shaw, Orcas and Friday Harbor[4]	N/C	N/C	N/C	N/A	N/C
Anacortes to Sidney and Sidney to all destinations	((~~20.25~~)) 21.30	((~~10.10~~)) 10.65	N/A	N/A	4.00[7]
From Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~12.65~~)) 13.40	((~~6.25~~)) 6.65	N/A	N/A	2.00[8]
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[3]	((~~25.05~~)) 26.30	((~~12.00~~)) 12.80	N/A	N/A	4.00[7]

All fares rounded to the next multiple of $0.05.

*These routes operate as a one-point toll collection system.

[1]MULTIRIDE MEDIA - Shall be valid only for 90 days from date of purchase after which time the tickets shall not be accepted for passage. Remaining value will not be eligible for refund or exchange. There shall be no commercial resale of this fare media. For mail order deliveries, WSF may add additional days to allow for delivery times.

[2]BICYCLE SURCHARGE - Is an addition to the appropriate passenger fare. Customers using multiride media and monthly passes are exempt from the bicycle surcharge. On all routes except Anacortes/San Juan Islands/Sidney, B.C., customers paying with the ePurse on the ORCA card are exempt from the bicycle surcharge. For the purposes of WSF fares determination, the bicycle fare category shall include both bicycles as defined by RCW 46.04.071 and electric-assisted bicycles as defined by RCW 46.04.169. Bicycles towing a kayak or canoe are to be charged the motorcycle/driver (stowage) rate in WAC 468-300-020. This rate includes the fare for the walk on passenger with the bicycle, and the kayak or canoe being towed by the bicycle. This requirement shall not apply to interisland travel in the San Juan Islands. All other bicycles towing trailers are charged the applicable bicycle surcharge.

[3]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the Islands served.

[4]INTER-ISLAND FARES - Passenger fares included in Anacortes tolls.

[5]PASSES - Passenger passes are available for all routes except Anacortes/San Juan Island/Sidney. Passes are valid for the period printed on the pass and will be presented to Washington state ferries staff or scanned through an automated turnstile whenever a passenger fare is collected. This pass is based on 16 days of passenger travel with a 20% discount. A $1.00 retail/shipping and handling fee will be added to the price of the pass.

A combination ferry-transit pass may be available for a particular route when determined by Washington state ferries and a local public transit agency to be a viable fare instrument. The WSF portion of the fare is based on 16 days of passenger travel per month at a 20% discount.

The monthly pass is valid for a maximum of 31 round trips per month, is nontransferable, is nonreproducible, and is intended for a single user. Monthly passes purchased through the regional SmartCard program are also nontransferable and intended for a single user, but allow for unlimited usage.

[6]BICYCLE SURCHARGE - This becomes $4.00 during peak season (May 1 through September 30).

[7]BICYCLE SURCHARGE - This becomes $6.00 during peak season.

[8]BICYCLE SURCHARGE - This becomes $3.00 during peak season.

[9]CAPITAL SURCHARGES - Included is a $0.25 capital surcharge on each single passenger fare collected. On all multiride cards except for Port Townsend/Coupeville, there is an included capital surcharge of $2.50. For Port Townsend/Coupeville, the included capital surcharge is $5.00 on multiride cards. On all monthly passes except Port Townsend/Coupeville, there is an included $4.00 capital surcharge. For Port Townsend/Coupeville, the included capital surcharge is $8.00 on monthly passes.

Beginning May 1, 2020, an additional $0.25 capital surcharge for new vessel construction is included on each single passenger fare collected. On all multiride cards except for Port Townsend/Coupeville, there is an included new vessel capital surcharge of $2.50. For Port Townsend/Coupeville, the included new vessel capital surcharge is $5.00 on multiride cards. On all monthly passes except Port Townsend/Coupeville, there is included a $4.00 new vessel capital surcharge. For Port Townsend/Coupeville, the included new vessel capital surcharge is $8.00 on monthly passes. For passenger half fare on Port Townsend/Coupeville the new vessel capital surcharge is $0.15.

CHILDREN/YOUTH - Children under six years of age will be carried free when accompanied by parent or guardian. Children/youths six through eighteen years of age will be charged the youth fare, which will be 50% of full fare rounded to the next multiple of $0.05.

SENIOR CITIZENS - Passengers age 65 and over, with proper identification establishing proof of age, may travel at half-fare passenger tolls on any route where passenger fares are collected.

((~~PERSONS OF DISABILITY - Any individual who, by reason of illness, injury, congenital malfunction, or other incapacity or disability is unable without special facilities or special planning or design to utilize ferry system services~~)) PEOPLE WITH DISABILITIES - Any person who has a physical or mental impairment that substantially limits one or more major life activity, upon presentation of a WSF Disability Travel Permit, Regional Reduced Fare Permit, or other identification which establishes a disability may travel at half-fare passenger tolls on any route where passenger fares are collected. In addition, ((~~those persons~~)) people with disabilities who require attendant care while traveling on the ferries, and are so certified by their physician, may obtain an endorsement on their WSF Disability Travel Permit and such endorsement shall allow the attendant to travel free as a passenger.

BUS PASSENGERS - Passengers traveling on public transit buses pay the applicable fare. Passengers traveling in private or commercial buses will be charged the half-fare rate.

MEDICARE CARD HOLDERS - Any person holding a medicare card duly issued to that person pursuant to Title II or Title XVIII of the Social Security Act may travel at half-fare passenger tolls on any route upon presentation of a WSF Disability Travel Permit or a Regional Reduced Fare Permit at time of travel.

IN-NEED ORGANIZATIONS - For qualified organizations serving in-need clients by providing tickets for transportation on WSF at no cost to clients, program would offer a monthly discount to approximate appropriate multiride media discount rates. Appointing bodies (those that appoint Ferry Advisory Committees) will nominate to the Washington State Transportation Commission those organizations that meet the criteria of the program. The Commission will review such nominations and certify those organizations that qualify. The following criteria will be used for nominating and certifying in-need organizations: Nongovernmental and not-for-profit organizations whose primary purpose is one or more of the following: Help clients with medical issues; provide clients with low-income social services; help clients suffering from domestic violence; provide clients with employment-seeking services; and/or help clients with Social Security. Travel will be initially charged based on full fare and billed monthly. The credits will be approximately based on the discount rates offered to multiride media users applicable on the date of travel.

PROMOTIONAL TOLLS - A promotional rate may be established at the discretion of the WSF Assistant Secretary, Executive Director for a specific discount in order to enhance total revenue and effective only at designated times on designated routes. A promotional fare product may also be estab-

lished to support tourism or other special events. The promotional fare or product may be bundled and sold as part of a multiparty promotional program.

Special passenger fare rate(s) may be established for a pilot program in conjunction with the Central Puget Sound Regional Fare Integration project on ferry route(s) serving King, Pierce, Snohomish and Kitsap counties. The rate(s) may be established at the discretion of the WSF Assistant Secretary, Executive Director for a specific discount not to exceed fifty percent of full fare.

SCHOOL GROUPS - Passengers traveling in authorized school groups, including home-school groups, for institution-sponsored activities will be charged a flat rate of $5 per walk-on group or per vehicle of students and/or advisors and staff. All school groups require a letter of authorization and prior notification. In the case of home-school groups, in addition to prior notification, a copy of the filed Declaration of Intent (as outlined in RCW 28A.200.010) shall be submitted to the tollbooth at time of travel. Notification shall be made no less than 72 hours before the scheduled departure and will include the expected number of school-age children and adults that will be traveling to ensure WSF can satisfy U.S. Coast Guard lifesaving equipment requirements. Failure to provide adequate notification may result in delayed travel. Vehicles and drivers will be charged the fare applicable to vehicle size. The special school rate is $10 on routes where one-point toll systems are in effect.

BUNDLED SINGLE FARE BOOKS - WSF may bundle single fare types into multiride media as a customer convenience. Remaining value will not be eligible for refund or exchange. For mail order deliveries, WSF may add additional days for delivery times.

FIRE DEPARTMENT AND FIRE DISTRICT FARE CONSIDERATION - At the discretion of the WSF Assistant Secretary, WSF may authorize no-fare or discounted fare passage on scheduled and/or special ferry sailings for fire departments and fire districts that provide contracted fire protection services for WSF ferry terminals and/or other WSF facilities within their jurisdiction. Such passage shall be considered full and complete consideration for such fire protection services, in lieu of annual payments for such services, to be so noted in such fire protection agreements. The scope of such authorization includes designated fire department and fire district vehicles (see below), drivers and passengers en route to and from an emergency call, on ferry routes with a WSF terminal and/or other WSF facility served by a fire department or fire district pursuant to a WSF fire protection service agreement. Authorized vehicles may include public fire department and fire district medical aid units, fire trucks, incident command and/or other vehicles dispatched to and returning from an emergency call.

GROUP OR VOLUME SALES - In order to increase total revenues, WSF may develop full fare or discounted customer packages or bundle single fare types into multiride media or offer passes for high volume or group users. In pricing these packages, WSF will have discretion to set appropriate volume discounts based on a case-by-case basis.

SPECIAL EVENTS - In order to increase total revenues, WSF may develop, create or participate in special events that may include, but not be limited to, contributing or packaging discounted fares in exchange for the opportunity to participate in the income generated by the event.

LOW-INCOME FARE PILOT - Starting no earlier than January 1, 2020, special passenger fare rate(s) may be established for a pilot program offering a low-income fare on any ferry route for riders made eligible through an existing transit agency's low-income fare program. Enactment of this program is dependent upon legislative funding for the pilot project. If funded, Washington State Ferries' Assistant Secretary shall submit a proposal to carry out this pilot program and the Washington State Transportation Commission must approve both the program and the fare schedule before it is implemented. Once implemented, WSF shall provide, at a minimum, updates to the Commission every six months on the pilot. The pilot will conclude no longer than three years from its implementation.

GOOD TO GO! PILOT - Special ferry toll rate(s) may be established for a pilot program of Good to Go! or similar fare collection infrastructure, technology, or ORCA replacement system on any ferry route. Washington State Ferries Assistant Secretary shall design the program and submit a proposed program and fare schedule to the Washington State Transportation Commission. The Commission shall review, modify and approve the proposed fare schedule and fare policies before it is implemented. Once implemented, WSF shall provide, at a minimum, updates to the Commission every six months on the pilot. The pilot will conclude no longer than three years from its implementation.

AMENDATORY SECTION (Amending WSR 17-18-018, filed 8/25/17, effective 9/25/17)

WAC 468-300-020 Vehicle under 22', motorcycle, and stowage ferry tolls.

EFFECTIVE 03:00 A.M. October 1, ((~~2017~~)) 2019

ROUTES	Vehicle Under 14' Incl. Driver One Way[7]	Vehicle Under 14' w/Sr Citizen or Disabled Driver[4, 7]	Vehicle under 14' Multiride Media 20 Rides[2, 7]
Fauntleroy-Southworth Port Townsend/Coupeville	((~~9.15~~)) 9.60	((~~7.50~~)) 7.90	((~~147.40~~)) 154.60
Seattle-Bainbridge Island Seattle-Bremerton Edmonds-Kingston	((~~11.80~~)) 12.35	((~~9.70~~)) 10.15	((~~189.80~~)) 198.60
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~15.05~~)) 15.75	((~~12.30~~)) 12.90	((~~120.90~~)) 126.50
Mukilteo-Clinton	((~~7.05~~)) 7.40	((~~5.75~~)) 6.10	((~~113.80~~)) 119.40
	10 Rides - 5 Round Trips		
*Anacortes to Lopez	((~~27.25~~)) 28.60	((~~20.45~~)) 21.60	((~~102.50~~)) 107.55
*Shaw, Orcas	((~~32.75~~)) 34.35	((~~25.95~~)) 27.35	((~~123.15~~)) 129.15
*Friday Harbor	((~~38.85~~)) 40.70	((~~32.05~~)) 33.70	((~~146.00~~)) 152.95
Between Lopez, Shaw, Orcas and Friday Harbor[3]	((~~16.15~~)) 16.95	((~~16.15~~)) 16.95	((~~64.85~~)) 68.05
International Travel			
Anacortes to Sidney and Sidney to all destinations	((~~44.65~~)) 46.75	((~~34.65~~)) 36.40	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~27.70~~)) 29.05	((~~21.40~~)) 22.55	N/A

ROUTES	Vehicle Under 14' Incl. Driver One Way[7]	Vehicle Under 14' w/Sr Citizen or Disabled Driver[4, 7]	Vehicle under 14' Multiride Media 20 Rides[2, 7]
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[5]	((~~55.15~~)) 57.85	((~~42.55~~)) 44.85	N/A

ROUTES	Vehicle 14' to Under 22' Incl. Driver One Way[7]	Vehicle 14' to Under 22' w/Sr Citizen or Disabled Driver[4, 7]	Vehicle 14' to Under 22' Multiride Media 20 Rides[2, 7]
Fauntleroy-Southworth Port Townsend/Coupeville	((~~11.60~~)) 12.20	((~~9.95~~)) 10.50	((~~186.60~~)) 196.20
Seattle-Bainbridge Island Seattle-Bremerton Edmonds-Kingston	((~~15.00~~)) 15.75	((~~12.90~~)) 13.55	((~~241.00~~)) 253.00
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~19.15~~)) 20.10	((~~16.40~~)) 17.25	((~~153.70~~)) 161.30
Mukilteo-Clinton	((~~8.95~~)) 9.40	((~~7.65~~)) 8.10	((~~144.20~~)) 151.40
	10 Rides - 5 Round Trips		
*Anacortes to Lopez	((~~34.15~~)) 35.90	((~~27.35~~)) 28.90	((~~128.40~~)) 134.95
*Shaw, Orcas	((~~40.95~~)) 43.05	((~~34.15~~)) 36.05	((~~153.90~~)) 161.75
*Friday Harbor	((~~48.65~~)) 51.10	((~~41.85~~)) 44.10	((~~182.75~~)) 191.95
Between Lopez, Shaw, Orcas and Friday Harbor[3]	((~~22.95~~)) 24.10	((~~22.95~~)) 24.10	((~~92.05~~)) 96.65
International Travel			
Anacortes to Sidney and Sidney to all destinations	((~~55.20~~)) 57.95	((~~45.20~~)) 47.60	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~34.25~~)) 36.00	((~~27.95~~)) 29.50	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[5]	((~~68.25~~)) 71.75	((~~55.65~~)) 58.75	N/A

EFFECTIVE 03:00 A.M. October 1, ((~~2017~~)) 2019

ROUTES	Motorcycle[5] Incl. Driver Stowage[1, 7] One Way	Motorcycle w/Sr Citizen or Disabled Driver Stowage[1, 7] One Way	Motorcycle Frequent User Commuter 20 Rides[2, 7]
Fauntleroy-Southworth Port Townsend/Coupeville	((~~5.05~~)) 5.25	((~~3.40~~)) 3.55	((~~81.80~~)) 85.00
Seattle-Bainbridge Island Seattle-Bremerton Edmonds-Kingston	((~~6.45~~)) 6.75	((~~4.35~~)) 4.55	((~~104.20~~)) 109.00
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~8.20~~)) 8.55	((~~5.45~~)) 5.70	((~~66.10~~)) 68.90
Mukilteo-Clinton	((~~3.95~~)) 4.10	((~~2.65~~)) 2.80	((~~64.20~~)) 66.60
*Anacortes to Lopez	((~~17.75~~)) 18.40	((~~10.95~~)) 11.40	((~~133.75~~)) 138.65
*Shaw, Orcas	((~~19.10~~)) 19.85	((~~12.30~~)) 12.85	((~~143.90~~)) 149.50
*Friday Harbor	((~~20.65~~)) 21.45	((~~13.85~~)) 14.45	((~~155.50~~)) 161.50
Between Lopez, Shaw, Orcas and Friday Harbor[3]	((~~6.50~~)) 6.80	((~~6.50~~)) 6.80	N/A
Anacortes to Sidney and Sidney to all destinations	((~~27.00~~)) 28.15	((~~17.00~~)) 17.80	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~16.80~~)) 17.50	((~~10.50~~)) 11.00	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[5]	((~~33.35~~)) 34.75	((~~20.75~~)) 21.75	N/A

All fares rounded to the next multiple of $0.05.

*These routes operate as a one-point toll collection system.

[1]SIZE - Vehicles under 14' in length shall pay the vehicle under 14' toll. Customers may be required to provide documentation, digitally or on paper, at the tollbooth to prove vehicle length. Documentation may include an owner's manual, materials from an auto research web site, or similar reference material that clearly lists the relevant vehicle specifications. All vehicles from 14' to under 22' in length shall pay the 14' to under 22' toll. Motorcycles towing a trailer and vehicles licensed as motorcycles with three or more wheels that are 8'0" or longer shall pay the appropriate length-based vehicle fare. Motorcycles include both mopeds and motorcycles as defined by RCW 46.04.304 and 46.04.330. Both are considered vehicles for the purposes of vehicle registration, license plate display, and WSF fare determination.

[2]MULTIRIDE MEDIA - Shall be valid only for 90 days from date of purchase after which time the media shall not be accepted for passage. Remaining value will not be eligible for refund or exchange. There shall be no commercial resale of this fare media. For mail order deliveries, WSF may add additional days to allow for delivery time. The vehicle/driver multiride card may be used for passage for an attendant driver plus one disabled driver.

[3]INTER-ISLAND FARES - Tolls collected westbound only. Vehicles traveling between islands may request a single transfer ticket good for one transfer at an intermediate island. The transfer may only be obtained when purchasing the appropriate vehicle fare for inter-island travel (westbound at Lopez, Shaw, or Orcas) and is free of charge. Transfers shall be valid ((~~for 24 hours from time~~)) until the end of the service day on the day of purchase.

[4]SENIOR CITIZENS((~~, DISABLED DRIVER OR DISABLED ATTENDANT DRIVER~~)) - Passengers age 65 and over, with proper identification establishing proof of age, may travel at half-fare passenger tolls on any route where passenger fares are collected. The half-fare discount applies to the driver portion of the vehicle-driver fare. The vehicle portion of the vehicle-driver fare is never further discounted.

PEOPLE WITH DISABILITIES - Any person who has a physical or mental impairment that substantially limits one or more major life activity, upon presentation of a WSF Disability Travel Permit, Reduced Fare Permit, or other identification which establishes a disability, may travel at half-fare passenger tolls on any route where passenger fares are collected. The half-fare discount applies to driver portion of the vehicle-driver fare ((~~and only when the driver is eligible. Those persons~~)). The vehicle portion of the vehicle-driver fare is never discounted. In addition, people with disabilities who require attendant care while traveling on the ferries, and are so certified by their physician, may obtain an endorsement on their WSF Disability Travel Permit and such endorsement shall allow the attendant((~~, when driving, to have the driver portion of the vehicle fare waived~~)) to travel free.

[5]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the islands served.

[6]VEHICLE RESERVATION DEPOSIT - Nonrefundable deposits for advance vehicle reservations may be established at a level of from 25 to 100 percent of the applicable 14' to under 22' standard vehicle one way fare. This is a deposit toward the fare and not an additional fee((~~,~~)) and applies only to those routes where the legislature has approved the use of a reservation system. Where it is operationally necessary (routes where vehicle fares are collected in only one direction or to increase operational efficiency at the terminal) a reservation no-show fee may be used in lieu of a deposit. The no-show fee will be limited to 25 to 100 percent of the ((~~equivalent one-way~~)) applicable one way 14' to under 22' standard vehicle fare and will be charged if the customer does not travel within the same ((~~business~~)) service day as their reserved sailing((~~. Refunds may be available under certain circumstances~~)), provided there are no service disruptions.

[7]CAPITAL SURCHARGE - Included is a $0.25 capital surcharge on each single vehicle/driver fare collected. On all multiride cards except for routes serving Vashon Island and the San Juan Islands, there is an included capital surcharge of $5.00. For Vashon Island routes, the included capital surcharge is $2.50 on multiride cards. For motorcycles in the San Juan Islands, the included capital surcharge on multiride cards is $2.50. For vehicles under 22' in the San Juan Islands, the included capital surcharge on multiride cards is $1.25.

RIDE SHARE VEHICLES - A commuter ride share vehicle which carries five or more persons on a regular and expense-sharing basis for the purpose of travel to and from work or school and which is certified as such by a local organization approved by the Washington state ferry system, may purchase for a $20 fee, a permit valid for one year valid only during the hours shown on the permit. The $20.00 fee shall include the driver. Remaining passengers shall pay the applicable passenger fare. Except that the minimum total paid for all passengers in the van shall not be less than four times the applicable passenger fare. Carpools of three or more registered in WSF's preferential loading program must also pay a $20.00 yearly permit fee.

STOWAGE - Stowage carry-on items including kayaks, canoes and other items of comparable size which are typically stowed on the vehicle deck of the vessel shall be charged at the motorcycle rate. This rate includes the walk-on passenger carrying on the item to be stowed.

PEAK SEASON SURCHARGE - A 25% surcharge shall be applied to vehicles from May 1 through September 30 except those using multiride media. A 35% surcharge shall be applied on vehicle fares from Anacortes to Lopez, Shaw, Orcas and Friday Harbor, except those using multiride media. The resulting fare is rounded to the nearest $0.05 if required.

FIRE DEPARTMENT AND FIRE DISTRICT FARE CONSIDERATION - At the discretion of the WSF Assistant Secretary, WSF may authorize no-fare or discounted fare passage on scheduled and/or special ferry sailings for fire departments and fire districts that provide contracted fire protection services for WSF ferry terminals and/or other WSF facilities within their jurisdiction. Such passage shall be considered full and complete consideration for such fire protection services, in lieu of annual payments for such services, to be so noted in such fire protection agreements. The scope of such authorization includes designated fire department and fire district vehicles (see below), drivers and passengers en route to and from an emergency call, on ferry routes with a WSF terminal and/or other WSF facility served by a fire department or fire district pursuant to a WSF fire protection service agreement. Authorized vehicles may include public fire department and fire district medical aid units, fire trucks, incident command and/or other vehicles dispatched to and returning from an emergency call.

IN-NEED ORGANIZATIONS - For qualified organizations serving in-need clients by providing tickets for transportation on WSF at no cost to clients, program would offer a monthly discount to approximate appropriate multiride media discount rates (20% off base season rates, except for Anacortes to San Juan Islands where it is 35% off base season end of week rates). Appointing bodies (those that appoint Ferry Advisory Committees) will nominate to the Washington State Transportation Commission those organizations that meet the criteria of the program. The Commission will review such nominations and certify those organizations that qualify. The following criteria will be used for nominating and certifying in-need organizations: Nongovernmental and not-for-profit organizations whose primary purpose is one or more of the following: Help clients with medical issues; provide clients with low-income social services; help clients suffering from domestic violence; provide clients with employment-seeking services; and/or help clients with Social Security. Travel will be initially charged based on full fare and billed monthly. The credits will be approximate based on the discount rates offered to multiride media users applicable on the date of travel.

PENALTY CHARGES - Owner of vehicle without driver will be assessed a $100.00 penalty charge.

PROMOTIONAL TOLLS - A promotional rate may be established at the discretion of the WSF Assistant Secretary, Executive Director for a specified discount in order to enhance total revenue and effective only at designated times on designated routes. A promotional fare product may also be established to support tourism or other special events. The promotional fare or product may be bundled and sold as part of a multiparty promotional program.

GROUP OR VOLUME SALES - In order to increase total revenues, WSF may develop full fare or discounted customer packages or bundle single fare types into multiride media or offer passes for high volume or group users. In pricing these packages, WSF will have discretion to set appropriate volume discounts based on a case-by-case basis.

SPECIAL EVENTS - In order to increase total revenues, WSF may develop, create or participate in special events that may include, but not be limited to, contributing or packaging discounted fares in exchange for the opportunity to participate in the income generated by the event.

BUNDLED SINGLE FARE MEDIA - WSF may bundle single fare types into multiple trip books as a customer convenience. Remaining value will not be eligible for refund or exchange. For mail order deliveries, WSF may add additional days to allow for delivery time.

GOOD TO GO! PILOT - Special ferry toll rate(s) may be established for a pilot program of Good to Go! or similar fare collection infrastructure, technology, or ORCA replacement system on any ferry route. Washington State Ferries Assistant Secretary shall design the program and submit a proposed program and fare schedule to the Washington State Transportation Commission. The Commission shall review, modify and approve the proposed fare schedule and fare policies before it is implemented. Once implemented, WSF shall provide, at a minimum, updates to the Commission every six months on the pilot. The pilot will conclude no longer than three years from its implementation.

EFFECTIVE 03:00 A.M. ((~~October 1, 2018~~)) May 1, 2020

ROUTES	Vehicle Under 14' Incl. Driver One Way[7]	Vehicle Under 14' w/Sr Citizen or Disabled Driver[4, 7]	Vehicle Under 14' Multiride Media 20 Rides[2, 7]
Fauntleroy-Southworth Port Townsend/Coupeville	((~~9.35~~)) 10.05	((~~7.65~~)) 8.25	((~~150.60~~)) 162.80
Seattle-Bainbridge Island Seattle-Bremerton Edmonds-Kingston	((~~12.05~~)) 12.90	((~~9.90~~)) 10.60	((~~193.80~~)) 208.40
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~15.40~~)) 16.40	((~~12.60~~)) 13.40	((~~123.70~~)) 132.20
Mukilteo-Clinton	((~~7.20~~)) 7.85	((~~5.90~~)) 6.45	((~~116.20~~)) 127.60
	10 Rides - 5 Round Trips		
*Anacortes to Lopez	((~~27.90~~)) 29.55	((~~20.95~~)) 22.30	((~~104.95~~)) 111.45
*Shaw, Orcas	((~~33.50~~)) 35.45	((~~26.55~~)) 28.20	((~~125.95~~)) 133.55
*Friday Harbor	((~~39.70~~)) 41.95	((~~32.75~~)) 34.70	((~~149.20~~)) 157.95
Between Lopez, Shaw, Orcas and Friday Harbor[3]	((~~16.50~~)) 17.65	((~~16.50~~)) 17.65	((~~66.25~~)) 71.10
International Travel			
Anacortes to Sidney and Sidney to all destinations	((~~45.70~~)) 48.15	((~~35.50~~)) 37.50	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~28.40~~)) 30.00	((~~22.00~~)) 23.25	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[5]	((~~56.55~~)) 59.50	((~~43.75~~)) 46.00	N/A

EFFECTIVE 03:00 A.M. ((~~October 1, 2018~~)) May 1, 2020

ROUTES	Vehicle 14' to Under 22' Incl. Driver One Way[7]	Vehicle 14' to Under 22' w/Sr Citizen or Disabled Driver[4, 7]	Vehicle 14' to Under 22' Multiride Media 20 Rides[2, 7]
Fauntleroy-Southworth Port Townsend/Coupeville[6]	((~~11.90~~)) 12.75	((~~10.20~~)) 10.95	((~~191.40~~)) 206.00
Seattle-Bainbridge Island Seattle-Bremerton Edmonds-Kingston	((~~15.35~~)) 16.40	((~~13.20~~)) 14.10	((~~246.60~~)) 264.40
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~19.60~~)) 20.85	((~~16.80~~)) 17.85	((~~157.30~~)) 167.80
Mukilteo-Clinton	((~~9.15~~)) 9.90	((~~7.85~~)) 8.50	((~~147.40~~)) 160.40
	10 Rides - 5 Round Trips		
*Anacortes to Lopez[6]	((~~35.00~~)) 37.05	((~~28.05~~)) 29.80	((~~131.55~~)) 139.55
*Shaw, Orcas[6]	((~~41.95~~)) 44.40	((~~35.00~~)) 37.15	((~~157.65~~)) 167.15
*Friday Harbor[6]	((~~49.80~~)) 52.65	((~~42.85~~)) 45.40	((~~187.05~~)) 198.05
Between Lopez, Shaw, Orcas and Friday Harbor[3]	((~~23.50~~)) 25.00	((~~23.50~~)) 25.00	((~~94.25~~)) 100.50
International Travel			
Anacortes to Sidney and Sidney to all destinations[6]	((~~56.55~~)) 59.65	((~~46.35~~)) 49.00	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~35.10~~)) 37.15	((~~28.70~~)) 30.40	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[6]	((~~69.95~~)) 73.80	((~~57.15~~)) 60.30	N/A

EFFECTIVE 03:00 A.M. ((~~October 1, 2018~~)) May 1, 2020

ROUTES	Motorcycle[5] Incl. Driver Stowage[1, 7] One Way	Motorcycle w/Sr Citizen or Disabled Driver Stowage[1, 7] One Way	Motorcycle Frequent User Commuter 20 Rides[2, 7]
Fauntleroy-Southworth Port Townsend/Coupeville[6]	((~~5.15~~)) 5.60	((~~3.45~~)) 3.80	((~~83.40~~)) 91.60
Seattle-Bainbridge Island Seattle-Bremerton Edmonds-Kingston	((~~6.60~~)) 7.15	((~~4.45~~)) 4.85	((~~106.60~~)) 116.40
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	((~~8.40~~)) 8.95	((~~5.60~~)) 5.95	((~~67.70~~)) 72.60
Mukilteo-Clinton	((~~4.00~~)) 4.45	((~~2.70~~)) 3.05	((~~65.00~~)) 73.20
*Anacortes to Lopez[6]	((~~18.10~~)) 19.05	((~~11.15~~)) 11.80	((~~136.40~~)) 144.15
*Shaw, Orcas[6]	((~~19.50~~)) 20.50	((~~12.55~~)) 13.25	((~~146.90~~)) 155.00
*Friday Harbor[6]	((~~21.05~~)) 22.15	((~~14.10~~)) 14.90	((~~158.50~~)) 167.40
Between Lopez, Shaw, Orcas and Friday Harbor[3]	((~~6.65~~)) 7.20	((~~6.65~~)) 7.20	N/A
Anacortes to Sidney and Sidney to all destinations[6]	((~~27.60~~)) 29.00	((~~17.40~~)) 18.35	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney	((~~17.20~~)) 18.15	((~~10.80~~)) 11.40	N/A
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[6]	((~~34.15~~)) 35.80	((~~21.35~~)) 22.30	N/A

All fares rounded to the next multiple of $0.05.

*These routes operate as a one-point toll collection system.

[1]SIZE - Vehicles under 14' in length shall pay the vehicle under 14' toll. Customers may be required to provide documentation, digitally or on paper, at the tollbooth to prove vehicle length. Documentation may include an owner's manual, materials from an auto research web site, or similar reference material that clearly lists the relevant vehicle specifications. Vehicles from 14' to under 22' shall pay the 14' to under 22' toll. Motorcycles towing a trailer and vehicles licensed as motorcycles with three or more wheels that are 8'0" or longer shall pay the appropriate length-based vehicle fare. Motorcycles include both mopeds and motorcycles as defined by RCW 46.04.304 and 46.04.330. Both are considered vehicles for the purposes of vehicle registration, license plate display, and WSF fare determination.

[2]MULTIRIDE MEDIA - Shall be valid only for 90 days from date of purchase after which time the media shall not be accepted for passage. Remaining value will not be eligible for refund or exchange. There shall be no commercial resale of this fare media. For mail order deliveries, WSF may add additional days to allow for delivery time. The vehicle/driver multiride card may be used for passage for an attendant driver plus one disabled passenger.

[3]INTER-ISLAND FARES - Tolls collected westbound only. Vehicles traveling between islands may request a single transfer ticket good for one transfer at an intermediate island. The transfer may only be obtained when purchasing the appropriate vehicle fare for inter-island travel (westbound at Lopez, Shaw, or Orcas) and is free of charge. Transfers shall be valid ((~~for 24 hours from time~~)) until the end of the service day on the day of purchase.

[4]SENIOR CITIZENS((~~, DISABLED DRIVER OR DISABLED ATTENDANT DRIVER~~)) - Passengers age 65 and over, with proper identification establishing proof of age, may travel at half-fare passenger tolls on any route where passenger fares are collected. The half-fare discount applies to the driver portion of the vehicle-driver fare. The vehicle portion of the vehicle-driver fare is never further discounted.

PEOPLE WITH DISABILITIES - Any person who has a physical or mental impairment that substantially limits one or more major life activity, upon presentation of a WSF Disability Travel Permit, Reduced Fare Permit, or other identification which establishes a disability, may travel at half-fare passenger tolls on any route where passenger fares are collected. The half-fare discount applies to driver portion of the vehicle-driver fare ((~~and only when the driver is eligible. Those persons~~)). The vehicle portion of the vehicle-driver fare is never discounted. In addition, people with disabilities who require attendant care while traveling on the ferries, and are so certified by their physician, may obtain an endorsement on their WSF Disability Travel Permit and such endorsement shall allow the attendant((~~, when driving, to have the driver portion of the vehicle fare waived~~)) to travel free.

[5]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the islands served.

[6]VEHICLE RESERVATION DEPOSIT - Nonrefundable deposits for advance vehicle reservations may be established at a level of from 25 to 100 percent of the applicable 14' to under 22' standard vehicle one way fare. This is a deposit toward the fare and not an additional fee((~~,~~)) and applies only to those routes where the legislature has approved the use of a reservation system. Where it is operationally necessary (routes where vehicle fares are collected in only one direction or to increase operational efficiency at the terminal) a reservation no-show fee may be used in lieu of a deposit. The no-show fee will be limited to 25 to 100 percent of the ((~~equivalent one-way~~)) applicable one way 14' to under 22' standard vehicle fare and will be charged if the customer does not travel within the same ((~~business~~)) service day as their reserved sailing((~~. Refunds may be available under certain circumstances~~)), provided there are no service disruptions.

[7]CAPITAL SURCHARGES - Included is a $0.25 capital surcharge on each single vehicle/driver fare collected. On all multiride cards except for routes serving Vashon Island and the San Juan Islands, there is an included capital surcharge of $5.00. For Vashon Island routes, the included capital surcharge is $2.50 on multiride cards. For motorcycles in the San Juan Islands, the capital surcharge included on multiride cards is $2.50. For vehicles under 22' in the San Juan Islands, the capital surcharge included on multiride cards is $1.25.

Beginning May 1, 2020, an additional $0.25 capital surcharge for new vessel construction is included on each single vehicle/driver fare collected. Included is a $0.25 new vessel capital surcharge on each single vehicle/driver fare collected. On all multiride cards except for routes serving Vashon Island and the San Juan Islands, there is an included new vessel capital surcharge of $5.00. For Vashon Island routes, the included new

vessel capital surcharge is $2.50 on multiride cards. For motorcycles in the San Juan Islands, the included new vessel capital surcharge on multiride cards is $2.50. For vehicles under 22' in the San Juan Islands, the included new vessel capital surcharge on multiride cards is $1.25.

RIDE SHARE VEHICLES - A commuter ride share vehicle which carries five or more persons on a regular and expense-sharing basis for the purpose of travel to and from work or school and which is certified as such by a local organization approved by the Washington state ferry system, may purchase for a $20 fee, a permit valid for one year valid only during the hours shown on the permit. The $20.00 fee shall include the driver. Remaining passengers shall pay the applicable passenger fare. Except that the minimum total paid for all passengers in the van shall not be less than four times the applicable passenger fare. Carpools of three or more registered in WSF's preferential loading program must also pay a $20.00 yearly permit fee.

STOWAGE - Stowage carry-on items including kayaks, canoes and other items of comparable size which are typically stowed on the vehicle deck of the vessel shall be charged at the motorcycle rate. This rate includes the walk-on passenger carrying on the item to be stowed.

PEAK SEASON SURCHARGE - A 25% surcharge shall be applied to vehicles from May 1 through September 30 except those using multiride media. A 35% surcharge shall be applied on vehicle fares from Anacortes to Lopez, Shaw, Orcas and Friday Harbor, except those using multiride media. The resulting fare is rounded up to the next $0.05 if required.

FIRE DEPARTMENT AND FIRE DISTRICT FARE CONSIDERATION - At the discretion of the WSF Assistant Secretary, WSF may authorize no-fare or discounted fare passage on scheduled and/or special ferry sailings for fire departments and fire districts that provide contracted fire protection services for WSF ferry terminals and/or other WSF facilities within their jurisdiction. Such passage shall be considered full and complete consideration for such fire protection services, in lieu of annual payments for such services, to be so noted in such fire protection agreements. The scope of such authorization includes designated fire department and fire district vehicles (see below), drivers and passengers en route to and from an emergency call, on ferry routes with a WSF terminal and/or other WSF facility served by a fire department or fire district pursuant to a WSF fire protection service agreement. Authorized vehicles may include public fire department and fire district medical aid units, fire trucks, incident command and/or other vehicles dispatched to and returning from an emergency call.

IN-NEED ORGANIZATIONS - For qualified organizations serving in-need clients by providing tickets for transportation on WSF at no cost to clients, program would offer a monthly discount to approximate appropriate multiride media discount rates (20% off base season rates, except for Anacortes to San Juan Islands where it is 35% off base season end of week rates). Appointing bodies (those that appoint Ferry Advisory Committees) will nominate to the Washington State Transportation Commission those organizations that meet the criteria of the program. The Commission will review such nominations and certify those organizations that qualify. The following criteria will be used for nominating and certifying in-need organizations: Nongovernmental and not-for-profit organizations whose primary purpose is one or more of the following: Help clients with medical issues; provide clients with low-income social services; help clients suffering from domestic violence; provide clients with employment-seeking services; and/or help clients with Social Security. Travel will be initially charged based on full fare and billed monthly. The credits will be approximate based on the discount rates offered to multiride media users applicable on the date of travel.

PENALTY CHARGES - Owner of vehicle without driver will be assessed a $100.00 penalty charge.

PROMOTIONAL TOLLS - A promotional rate may be established at the discretion of the WSF Assistant Secretary, Executive Director for a specified discount in order to enhance total revenue and effective only at designated times on designated routes. A promotional fare product may also be established to support tourism or other special events. The promotional fare or product may be bundled and sold as part of multiparty promotional program.

GROUP OR VOLUME SALES - In order to increase total revenues, WSF may develop full fare or discounted customer packages or bundle single fare types into multiride media or offer passes for high volume or group users. In pricing these packages, WSF will have discretion to set appropriate volume discounts based on a case-by-case basis.

SPECIAL EVENTS - In order to increase total revenues, WSF may develop, create or participate in special events that may include, but not be limited to, contributing or packaging discounted fares in exchange for the opportunity to participate in the income generated by the event.

BUNDLED SINGLE FARE MEDIA - WSF may bundle single fare types into multiple trip books as a customer convenience. Remaining value will not be eligible for refund or exchange. For mail order deliveries, WSF may add additional days to allow for delivery time.

GOOD TO GO! PILOT - Special ferry toll rate(s) may be established for a pilot program of Good to Go! or similar fare collection infrastructure, technology, or ORCA replacement system on any ferry route. Washington State Ferries Assistant Secretary shall design the program and submit a proposed program and fare schedule to the Washington State Transportation Commission. The Commission shall review, modify and approve the proposed fare schedule and fare policies before it is implemented. Once implemented, WSF shall provide, at a minimum, updates to the Commission every six months on the pilot. The pilot will conclude no longer than three years from its implementation.

AMENDATORY SECTION (Amending WSR 17-18-018, filed 8/25/17, effective 9/25/17)

WAC 468-300-040 Oversize vehicle ferry tolls.

EFFECTIVE 03:00 A.M. October 1, ((~~2017~~)) 2019

((~~Oversize Vehicle Ferry Tolls[1]~~
~~Overall Unit Length - Including Driver~~

~~ROUTES~~	~~22' To Under 30' Under 7'2" High[5]~~	~~22' To Under 30' Over 7'2" High[5]~~	~~30' To Under 40'[5]~~	~~40' To Under 50'[5]~~	~~50' To Under 60'[5]~~	~~60' To under 70'[5]~~	~~70' To and include 80'[5]~~	~~Cost Per Ft. Over 80' @~~
~~Fauntleroy-Southworth Port Townsend/Coupeville~~	~~17.70~~	~~35.15~~	~~46.75~~	~~58.40~~	~~70.00~~	~~81.65~~	~~93.25~~	~~1.15~~
~~Seattle-Bainbridge Island Seattle/Bremerton Edmonds-Kingston~~	~~22.90~~	~~45.55~~	~~60.65~~	~~75.75~~	~~90.85~~	~~105.95~~	~~121.05~~	~~1.50~~

((~~Oversize Vehicle Ferry Tolls[1]~~
~~Overall Unit Length - Including Driver~~

ROUTES	~~22' To Under 30' Under 7'2" High[5]~~	~~22' To Under 30' Over 7'2" High[5]~~	~~30' To Under 40'[5]~~	~~40' To Under 50'[5]~~	~~50' To Under 60'[5]~~	~~60' To under 70'[5]~~	~~70' To and include 80'[5]~~	~~Cost Per Ft. Over 80' @~~
~~*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah~~	~~29.25~~	~~58.25~~	~~77.55~~	~~96.90~~	~~116.20~~	~~135.55~~	~~154.85~~	~~1.95~~
~~Mukilteo-Clinton~~	~~13.65~~	~~27.00~~	~~35.90~~	~~44.80~~	~~53.70~~	~~62.60~~	~~71.50~~	~~0.90~~
~~*Anacortes to Lopez[2]~~	~~52.35~~	~~104.45~~	~~139.15~~	~~173.90~~	~~208.65~~	~~243.35~~	~~278.10~~	~~3.50~~
~~*Anacortes to Shaw, Orcas[2]~~	~~62.80~~	~~125.30~~	~~166.95~~	~~208.65~~	~~250.30~~	~~292.00~~	~~333.65~~	~~4.15~~
~~*Anacortes to Friday Harbor~~	~~74.55~~	~~148.85~~	~~198.35~~	~~247.90~~	~~297.40~~	~~346.95~~	~~396.45~~	~~4.95~~
~~Between Lopez, Shaw, Orcas and Friday Harbor[3]~~	~~35.15~~	~~70.00~~	~~93.25~~	~~116.50~~	~~139.75~~	~~163.05~~	~~186.30~~	~~N/A~~
~~*International Travel* Anacortes to Sidney to all destinations~~	~~85.45~~	~~85.45~~	~~113.90~~	~~142.30~~	~~170.70~~	~~199.10~~	~~227.50~~	~~2.85~~
~~Lopez, Shaw, Orcas and Friday Harbor to Sidney~~	~~53.05~~	~~53.05~~	~~70.60~~	~~88.20~~	~~105.80~~	~~123.40~~	~~140.95~~	~~1.75~~
~~Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[4]~~	~~105.85~~	~~105.85~~	~~140.95~~	~~176.15~~	~~211.35~~	~~246.55~~	~~281.65~~	~~3.50~~))

Oversize Vehicle Ferry Tolls[1]
Overall Unit Length - Including Driver

ROUTES	22' To Under 30' Under 7'2" High[5]	22' To Under 30' 7'2" High or Over[5]	30' To Under 40'[5]	40' To Under 50'[5]	50' To Under 60'[5]	60' To under 70'[5]	70' To and include 80'[5]	Cost Per Ft. Over 80'
Fauntleroy-Southworth Port Townsend/Coupeville	18.15	36.05	48.00	59.95	71.85	83.80	95.75	1.20
Seattle-Bainbridge Island Seattle/Bremerton Edmonds-Kingston	23.50	46.75	62.25	77.75	93.25	108.75	124.25	1.55
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	30.00	59.75	79.60	99.45	119.30	139.15	158.95	2.00
Mukilteo-Clinton	14.00	27.70	36.85	45.95	55.10	64.25	73.40	0.90
*Anacortes to Lopez[2]	53.75	107.20	142.85	178.50	214.15	249.80	285.45	3.55
*Anacortes to Shaw, Orcas[2]	64.40	128.60	171.35	214.15	256.95	299.70	342.50	4.30
*Anacortes to Friday Harbor	76.50	152.75	203.60	254.45	305.30	356.15	406.95	5.10
Between Lopez, Shaw, Orcas and Friday Harbor[3]	36.05	71.85	95.75	119.60	143.45	167.35	191.20	N/A
International Travel Anacortes to Sidney to all destinations	91.95	91.95	122.55	153.10	183.65	214.25	244.80	3.05
Lopez, Shaw, Orcas and Friday Harbor to Sidney	57.05	57.05	76.00	94.90	113.85	132.75	151.70	1.90
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[4]	113.85	113.85	151.75	189.55	227.45	265.25	303.15	3.80

[1]OVERSIZE VEHICLES - Includes all vehicles 22 feet in length and longer regardless of type: Commercial trucks, recreational vehicles, vehicles under 22' pulling trailers, etc. Length shall include vehicle and load to its furthest extension. Overheight charge is included in oversize vehicle toll. Vehicles wider than 8'6" pay double the fare applicable to their length. Private and commercial passenger buses or other passenger vehicles pay the applicable oversize vehicle tolls. Public transit buses and drivers shall travel free upon display of an annual permit which may be purchased for $10. Upon presentation by either the driver or passenger of a WSF Disability Travel Permit, Regional Reduced Fare Permit, or other identification which establishes disability, vehicles 22-30 feet in length and ((~~over~~)) 7'2" or over in height shall be charged the 22-30 foot length and under 7'2" in height fare for vehicles equipped with wheelchair lift or other feature designed to accommodate the person with the disability.

[2]TRANSFERS - Tolls collected westbound only. Oversize vehicles traveling westbound from Anacortes may ((~~purchase~~)) receive a single intermediate transfer when first purchasing the ((~~appropriate~~)) fare for the furthest intended point of travel for the trip. The transfer is valid ((~~for a 24-hour period and is priced as follows: $64.40 base season, $86.80 peak season~~)) until the end of the service day on the day purchased.

[3]INTER-ISLAND - Tolls collected westbound only. Vehicles traveling between islands may request a single transfer ticket good for one transfer at an intermediate island. The transfer may only be obtained when purchasing the appropriate vehicle fare for inter-island travel (westbound at Lopez, Shaw, or Orcas) and is free of charge. Transfers shall be valid ((~~for 24 hours from time~~)) until the end of the service day on the day of purchase.

[4]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the islands served.

[5]CAPITAL SURCHARGE - There is an included $0.25 capital surcharge on each single vehicle/driver fare collected.

BULK NEWSPAPERS - Per 100 lbs. $2.85 (Shipments exceeding 60,000 lbs. in any month shall be assessed $1.42 per 100 lbs.). Daily newspapers, in bundles, to be received and delivered without receipt and subject to owner's risk, will be transported between ferry terminals on regular scheduled sailings.

VEHICLE RESERVATION DEPOSIT - Nonrefundable deposits for advanced reservations may be established at a level of from 25 to 100 percent of the applicable oversize vehicle one way fare. This is a deposit toward the fare and not an additional fee((,)) and applies only to those routes where the legislature has approved the use of a reservation system. Where it is operationally necessary (routes where vehicle fares are collected in only one direction or to increase operational efficiency at the terminal) a reservation no-show fee may be used in lieu of a deposit. The no-show fee will be limited to 25 to 100 percent of the ((~~equivalent one-way~~)) applicable one way oversize vehicle fare and will be charged if the customer does not travel within the same ((~~business~~)) service day as their reserved sailing((~~. Refunds may be available under certain special circumstances~~)), provided there are no service disruptions.

PEAK SEASON SURCHARGE - A peak season surcharge shall apply to all oversize vehicles from May 1 through September 30. The oversize fare shall be determined based on the peak-season car-and-driver fare and the analogous oversize vehicle fare, calculated with the same factor as the oversize base seasons fares are to the base season under 20 foot fare. The senior citizen discount shall apply to the driver of an oversize vehicle. The resulting fare is rounded up to the next $0.05 if required.

SENIOR CITIZEN DISCOUNTS - Discounts of 50% for the driver of the above vehicles shall apply. Senior citizen discount is determined by subtracting full-fare passenger rate and adding half-fare passenger rate. The senior citizen discount shall apply to the driver of an oversize vehicle.

PENALTY CHARGES - Owner of vehicle without driver will be assessed a $100.00 penalty charge.

COMMERCIAL ACCOUNTS - Commercial customers making 12 or more, one-way crossings per week (Sunday through Saturday) will qualify for a 10% discount from the regular ferry tolls. WSF will provide a commercial account program that will be prepaid and offer access to volume discounts based on travel, revenue or other criteria in accordance with WSF business rules. On an annual basis, commercial accounts will pay a $50 nonrefundable account maintenance fee.

GROUP OR VOLUME SALES - In order to increase total revenues, WSF may develop full fare or discounted customer packages or bundle single fare types into multiple trip books or offer passes for high volume or group users. In pricing these packages, WSF will have discretion to set appropriate volume discounts based on a case-by-case basis.

SPECIAL EVENTS - In order to increase total revenues, WSF may develop, create or participate in special events that may include, but not be limited to, contributing or packaging discounted fares in exchange for the opportunity to participate in the income generated by the event.

FIRE DEPARTMENT AND FIRE DISTRICT FARE CONSIDERATION - At the discretion of the WSF Assistant Secretary, WSF may authorize no-fare or discounted fare passage on scheduled and/or special ferry sailings for fire departments and fire districts that provide contracted fire protection services for WSF ferry terminals and/or other WSF facilities within their jurisdiction. Such passage shall be considered full and complete consideration for such fire protection services, in lieu of annual payments for such services, to be so noted in such fire protection agreements. The scope of such authorization includes designated fire department and fire district vehicles (see below), drivers and passengers en route to and from an emergency call, on ferry routes with a WSF terminal and/or other WSF facility served by a fire department or fire district pursuant to a WSF fire protection service agreement. Authorized vehicles may include public fire department and fire district medical aid units, fire trucks, incident command and/or other vehicles dispatched to and returning from an emergency call.

EMERGENCY TRIPS DURING NONSERVICE HOURS - While at locations where crew is on duty charge shall be equal to the cost of fuel consumed to make emergency trip. Such trips shall only be offered as a result of official requests from an emergency services agency and only in the case of no reasonable alternative.

DISCLAIMER - Under no circumstances does Washington state ferries warrant the availability of ferry service at a given date or time; nor does it warrant the availability of space on board a vessel on a given sailing.

GOOD TO GO! PILOT - Special ferry toll rate(s) may be established for a pilot program of Good to Go! or similar fare collection infrastructure, technology, or ORCA replacement system on any ferry route. Washington State Ferries Assistant Secretary shall design the program and submit a proposed program and fare schedule to the Washington State Transportation Commission. The Commission shall review, modify and approve the proposed fare schedule and fare policies before it is implemented. Once implemented, WSF shall provide, at a minimum, updates to the commission every six months on the pilot. The pilot will conclude no longer than three years from its implementation.

EFFECTIVE 03:00 A.M. ((~~October 1, 2018~~)) May 1, 2020

((~~Oversize Vehicle Ferry Tolls[1]~~
~~Overall Unit Length - Including Driver~~

~~ROUTES~~	~~22' To Under 30' Under 7'2" High[5]~~	~~22' To Under 30' Over 7'2" High[5]~~	~~30' To Under 40'[5]~~	~~40' To Under 50'[5]~~	~~50' To Under 60'[5]~~	~~60' To under 70'[5]~~	~~70' To and include 80'[5]~~	~~Cost Per Ft. Over 80' @~~
~~Fauntleroy-Southworth Port Townsend/Coupeville~~	~~17.70~~	~~35.15~~	~~46.75~~	~~58.40~~	~~70.00~~	~~81.65~~	~~93.25~~	~~1.15~~
~~Seattle-Bainbridge Island Seattle/Bremerton Edmonds-Kingston~~	~~22.90~~	~~45.55~~	~~60.65~~	~~75.75~~	~~90.85~~	~~105.95~~	~~121.05~~	~~1.50~~

((~~Oversize Vehicle Ferry Tolls[1]~~
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ROUTES	~~22' To Under 30' Under 7'2" High[5]~~	~~22' To Under 30' Over 7'2" High[5]~~	~~30' To Under 40'[5]~~	~~40' To Under 50'[5]~~	~~50' To Under 60'[5]~~	~~60' To under 70'[5]~~	~~70' To and include 80'[5]~~	~~Cost Per Ft. Over 80' @~~
~~*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah~~	~~29.25~~	~~58.25~~	~~77.55~~	~~96.90~~	~~116.20~~	~~135.55~~	~~154.85~~	~~1.95~~
~~Mukilteo-Clinton~~	~~13.65~~	~~27.00~~	~~35.90~~	~~44.80~~	~~53.70~~	~~62.60~~	~~71.50~~	~~0.90~~
~~*Anacortes to Lopez[2]~~	~~52.35~~	~~104.45~~	~~139.15~~	~~173.90~~	~~208.65~~	~~243.35~~	~~278.10~~	~~3.50~~
~~*Anacortes to Shaw, Orcas[2]~~	~~62.80~~	~~125.30~~	~~166.95~~	~~208.65~~	~~250.30~~	~~292.00~~	~~333.65~~	~~4.15~~
~~*Anacortes to Friday Harbor~~	~~74.55~~	~~148.85~~	~~198.35~~	~~247.90~~	~~297.40~~	~~346.95~~	~~396.45~~	~~4.95~~
~~Between Lopez, Shaw, Orcas and Friday Harbor[3]~~	~~35.15~~	~~70.00~~	~~93.25~~	~~116.50~~	~~139.75~~	~~163.05~~	~~186.30~~	~~N/A~~
~~*International Travel* Anacortes to Sidney to all destinations~~	~~85.45~~	~~85.45~~	~~113.90~~	~~142.30~~	~~170.70~~	~~199.10~~	~~227.50~~	~~2.85~~
~~Lopez, Shaw, Orcas and Friday Harbor to Sidney~~	~~53.05~~	~~53.05~~	~~70.60~~	~~88.20~~	~~105.80~~	~~123.40~~	~~140.95~~	~~1.75~~
~~Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[4]~~	~~105.85~~	~~105.85~~	~~140.95~~	~~176.15~~	~~211.35~~	~~246.55~~	~~281.65~~	~~3.50~~))

Oversize Vehicle Ferry Tolls[1]
Overall Unit Length - Including Driver

ROUTES	22' To Under 30' Under 7'2" High[5]	22' To Under 30' 7'2" High or Over[5]	30' To Under 40'[5]	40' To Under 50'[5]	50' To Under 60'[5]	60' To under 70'[5]	70' To and include 80'[5]	Cost Per Ft. Over 80'
Fauntleroy-Southworth Port Townsend/Coupeville	18.90	37.25	49.45	61.70	73.95	86.20	98.45	1.25
Seattle-Bainbridge Island Seattle/Bremerton Edmonds-Kingston	24.35	48.20	64.10	80.00	95.90	111.80	127.70	1.60
*Fauntleroy-Vashon *Southworth-Vashon *Pt. Defiance-Tahlequah	31.05	61.55	81.90	102.25	122.60	142.95	163.30	2.05
Mukilteo-Clinton	14.60	28.65	38.00	47.40	56.80	66.15	75.55	0.95
*Anacortes to Lopez[2]	55.35	110.20	146.80	183.35	219.90	256.50	293.05	3.65
*Anacortes to Shaw, Orcas[2]	66.35	132.15	176.05	219.90	263.80	307.70	351.55	4.40
*Anacortes to Friday Harbor	78.75	156.95	209.10	261.25	313.40	365.55	417.70	5.20
Between Lopez, Shaw, Orcas and Friday Harbor[3]	37.25	73.95	98.45	122.95	147.40	171.90	196.40	N/A
International Travel Anacortes to Sidney to all destinations	99.00	99.00	131.80	164.65	197.50	230.30	263.15	3.30
Lopez, Shaw, Orcas and Friday Harbor to Sidney	61.50	61.50	81.85	102.15	122.50	142.80	163.15	2.05
Lopez, Shaw, Orcas and Friday Harbor to Sidney (round trip)[4]	122.50	122.50	163.20	203.80	244.50	285.10	325.80	4.10

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[2]TRANSFERS - Tolls collected westbound only. Oversize vehicles traveling westbound from Anacortes may ((~~purchase~~)) receive a single intermediate transfer when first purchasing the ((~~appropriate~~)) fare for the furthest intended point of travel for the trip. The transfer is valid ((~~for a 24-hour period and is priced as follows: $66.00 base season, $88.95 peak season~~)) until the end of the service day on the day purchased.

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[4]ROUND TRIP - Round trip passage for international travel available for trips beginning or ending on one of the islands served.

[5]CAPITAL SURCHARGES - There is included an additional $0.25 capital surcharge on each single vehicle/driver fare collected. Beginning May 1, 2020, an additional $0.25 capital surcharge for new vessel construction is included on each single vehicle/driver fare collected.

BULK NEWSPAPERS - Per 100 lbs. $2.85 (Shipments exceeding 60,000 lbs. in any month shall be assessed $1.42 per 100 lbs.). Daily newspapers, in bundles, to be received and delivered without receipt and subject to owner's risk, will be transported between ferry terminals on regular scheduled sailings.

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WSR 19-14-105

PROPOSED RULES

DEPARTMENT OF LICENSING

[Filed July 2, 2019, 11:06 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-01-106.

Title of Rule and Other Identifying Information: Chapter 308-104 WAC, Drivers' licenses.

Hearing Location(s): On August 12, 2019, at 5:00 p.m., at the Seattle Public Library, 1000 4th Avenue, Seattle, WA 98104; on August 13, 2019, at 5:00 p.m., at the Washington State Capitol, Columbia Room, 416 Sid Snyder Avenue S.W., Olympia, WA 98504; and on August 15, 2019, at 4:00 p.m., at the Spokane Public Library, 3324 South Perry Street, Spokane, WA 99203.

Date of Intended Adoption: August 16, 2019.

Submit Written Comments to: Ellis Starrett, P.O. Box 9020, Olympia, WA 98507, email RulesCoordinator@dol.wa.gov, by August 15, 2019.

Assistance for Persons with Disabilities: Contact Ellis Starrett, phone 360-902-3851, email estarrett@dol.wa.gov, by August 11, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposal will allow Washington state residents to select a nonbinary sex designation for driver licenses or identification cards.

Reasons Supporting Proposal: This WAC updates the department's policies and procedures for selecting a sex designation on a driver license or identification card. The new WAC allows nonbinary residents who are applying for a driver license or identification card to select a sex designation that accurately reflects their status as gender diverse, nonbinary, or gender nonconforming individuals.

Statutory Authority for Adoption: RCW 46.01.110.

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

Name of Proponent: Department of licensing, governmental.

Name of Agency Personnel Responsible for Drafting: Geoffrey Cunningham, Highways and Licenses Building, Olympia, Washington, 360-902-3655; Implementation and Enforcement: Greg Mukai, Highways and Licenses Building, Olympia, Washington, 360-902-3851.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This change relates to internal government operations.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

July 2, 2019
Damon Monroe
Rules Coordinator

NEW SECTION

WAC 308-104-0150 Changing sex designation on a driver's license, instruction permit, or identification card. (1) Persons may change the sex designation on a driver's license, instruction permit, or identification card by means of completing a sex designation change application signed under penalty of perjury pursuant to chapter 9A.72 RCW.

(2) For the purposes of this section, "X" means a sex that is not exclusively male or female.

WSR 19-14-123
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed July 3, 2019, 11:21 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-09-021.

Title of Rule and Other Identifying Information: WAC 182-547-0100 General, 182-547-0200 Definitions, 182-547-0700 Eligibility, 182-547-0800 Coverage—Clients age twenty years and younger, 182-547-0850 Coverage—Clients age twenty-one and older, 182-547-0900 Noncovered services—Clients age twenty-one and older, 182-547-1000 Prior authorization—Clients age twenty and younger, 182-547-1050 Prior authorization—Clients age twenty-one and older, and 182-547-1100 Reimbursement.

Hearing Location(s): On August 6, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Pear Conference Room 107, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than August 7, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by August 6, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by August 2, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is amending chapter 182-547 WAC, Hearing aids, to implement E2SSB 5179, which restores coverage of hearing instruments for adults.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; and E2SSB 5179, 65th legislature, 2018 regular session.

Statute Being Implemented: RCW 41.05.021, 41.05.160; and E2SSB 5179, 65th legislature, 2018 regular session.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Crabbe, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9563; Implementation and Enforcement: Jean Gowenl [Gowen], P.O. Box 45506, Olympia, WA 98504-5506, 360-725-2005.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

July 2, 2019
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-20-013, filed 9/20/13, effective 10/21/13)

WAC 182-547-0100 ((~~Hearing aids—General—For clients twenty years of age and younger.~~)) General. ((~~Unless otherwise defined in WAC 182-547-0200, the terms within this chapter are intended to correspond with the terms in chapter 18.35 RCW.~~))

(1) The medicaid agency covers the hearing aids listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter. See also WAC 182-531-0375 audiology services.

(2) The agency pays for hearing aids when:

(a) Covered;

(b) Within the scope of an eligible client's medical care program;

(c) Medically necessary as defined under WAC 182-500-0070;

(d) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices;

(e) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices; ((~~and~~))

(f) The client ((~~is twenty years of age or younger and~~)) completes a hearing evaluation, including an audiogram ((~~and/or~~)) or developmentally appropriate diagnostic physiologic test ((~~results performed and/or~~)), that is administered by and the results interpreted by a hearing health care professional; and

(g) The licensed audiologist, hearing aid specialist, otolaryngologist, or otologist concludes that the client may benefit from a hearing aid.

(3) The agency requires prior authorization for covered hearing aids when the clinical criteria set forth in this chapter are not met. The agency evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 182-501-0165.

AMENDATORY SECTION (Amending WSR 13-20-013, filed 9/20/13, effective 10/21/13)

WAC 182-547-0200 ((~~Hearing aids—~~))Definitions. The following definitions, the definitions found in RCW 18.35.010, and those found in chapter 182-500 WAC apply to this chapter.

"Bone-anchored hearing aid" or **"bone conduction hearing device"** means a type of hearing aid that transmits sound vibrations through bones in the head. The inner ear translates the vibrations the same way a normal ear translates sound waves. These devices can be surgically implanted or worn on headbands.

"Cochlear implant" means an electrical device that receives sound and transmits the resulting signal to electrodes implanted in the cochlea. That signal stimulates the cochlea so that hearing impaired persons can perceive sound.

"Digital hearing aids"((~~—Hearing aids~~)) means wearable sound-amplifying devices that use a digital circuit to analyze and process sound.

"Hearing aids"((~~—~~)) means wearable sound-amplifying devices that are intended to compensate for hearing loss. These devices use a digital circuit to analyze and process sound. Hearing aids are described by where they are worn in the ear as in-the-ear (ITE), behind-the-ear (BTE), etc. ((~~Hearing aids can also be described by how they process the amplified signal. This would include analog conventional, analog programmable, digital conventional, and digital programmable.~~))

"Hearing health care professional"((~~—~~)) means an audiologist or hearing aid ((~~fitter/dispenser~~)) specialist licensed under chapter 18.35 RCW, or ((~~an otorhinolaryngologist or otologist~~)) a physician specializing in diseases and disorders of the ear licensed under chapter 18.71 RCW.

"Maximum allowable fee"((~~—~~)) means the maximum dollar amount that the medicaid agency will pay a provider for specific services, supplies and equipment.

((~~**"Prior authorization"** — A form of authorization used by the provider to obtain approval for a specific hearing aid and service(s). The approval is based on medical necessity and must be received before the service(s) are provided to clients as a precondition for payment.~~))

AMENDATORY SECTION (Amending WSR 13-20-013, filed 9/20/13, effective 10/21/13)

WAC 182-547-0700 ((~~Hearing aids—Eligibility—Clients twenty years of age and younger.~~)) Eligibility. (1) Clients ((~~twenty years of age and younger who are receiving services under a medical assistance program:~~

~~(a) Are eligible for covered hearing aids under this chapter and for the audiology services under WAC 182-531-0375;~~

~~(b) Must have a complete hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed by a hearing health care professional; and~~

~~(c) Must be referred by a licensed audiologist, otorhinolaryngologist or otologist for a hearing aid~~)) covered by one of the Washington apple health programs as listed in the table in WAC 182-501-0060 are eligible for hearing aids and related services.

(2) Clients ((~~who are~~)) enrolled in ((~~an~~)) a medicaid agency-contracted managed care organization (MCO) ((~~are eligible under fee-for-service for covered hearing aid services that are not covered by their plan, subject to the provisions of this chapter and other applicable WAC. However~~)) must arrange for hearing aid and related services directly through the client's MCO. Additionally, clients enrolled in an agency-contracted MCO must obtain replacement parts for cochlear implants and bone-anchored hearing aids (((~~BAHA~~))), including batteries, through their MCO.

AMENDATORY SECTION (Amending WSR 15-03-042, filed 1/12/15, effective 2/12/15)

WAC 182-547-0800 ((~~Hearing aids—~~))Coverage—Clients age twenty years ((~~of age~~)) and younger. (1) The medicaid agency covers new, nonrefurbished, monaural or binaural hearing aid(s), which includes the ear molds, for eligible clients age twenty ((~~years of age~~)) and younger. In order for the provider to receive payment, the hearing aid must meet the client's specific hearing needs and carry a manufacturer's warranty for a minimum of one year.

(2) The agency pays for the following replacements as long as the need for replacement is not due to the client's carelessness, negligence, recklessness, deliberate intent, or misuse in accordance with WAC 182-501-0050(((~~(8)~~))):

(a) Hearing aid(s), which includes the ear molds, when:

(i) The client's hearing aid(s) are:

(A) Lost;

(B) Beyond repair; or

(C) Not sufficient for the client's hearing loss; and

(ii) All warranties are expired.

(b) Ear mold(s) when the client's existing ear mold is damaged or no longer fits the client's ear.

(3) The agency pays for repairs of hearing aids that are less than five years old as follows:

(a) A maximum of two repairs, per hearing aid, per year, when the repair is less than fifty percent of the cost of a new hearing aid. To receive payment, all of the following must be met:

(i) All warranties are expired; and

(ii) The repair warranty is for a minimum of six months.

(b) A rental hearing aid(s) for up to thirty days while the client's own hearing aid is being repaired. In the case of a rental hearing aid(s), the agency pays separately for an ear mold(s).

(4) The agency pays for cochlear implant and ((~~BAHA~~)) bone-anchored hearing aid replacement parts when:

(a) The manufacturer's warranty has expired;

(b) The part is for immediate use, not a back-up part; and

(c) The part needs to be replaced due to normal wear and tear and is not related to misuse or abuse of the item (see WAC ((~~182-502-0160~~)) 182-501-0050).

(5) The agency covers cochlear implant external ((~~speech~~)) sound processors, including maintenance and repair.

(6) The agency covers ((~~BAHA~~)) bone-anchored hearing aid speech processors, including maintenance and repair.

(7) The agency covers batteries for hearing aids, cochlear implant external ((~~speech~~)) sound processors, and ((~~BAHA speech~~)) bone-anchored hearing aid sound processors.

NEW SECTION

WAC 182-547-0850 Coverage—Clients age twenty-one and older. (1) **Nonrefurbished, monaural hearing aids.** The medicaid agency covers one new nonrefurbished monaural hearing aid, which includes the ear mold, every five years for clients age twenty-one and older.

(a) The client must have an average decibel loss of forty-five or greater in the better ear, based on a pure-tone audiometric evaluation by a licensed audiologist or a licensed hearing aid specialist at 1000, 2000, 3000, and 4000 hertz (Hz) with effective masking as indicated.

(b) The hearing aid must meet the client's specific hearing needs and carry a manufacturer's warranty for a minimum of one year.

(2) **Binaural hearing aids.** The agency covers binaural hearing aids with prior authorization (PA).

(3) **Replacement.** The agency covers the following replacements if the need for replacement is not due to the client's carelessness, negligence, recklessness, deliberate intent, or misuse under WAC 182-501-0050(7):

(a) One replacement hearing aid, including the ear mold, in a five-year period when the warranty is expired and the client's hearing aid(s) is:

(i) Lost; or

(ii) Broken and cannot be repaired.

(b) One replacement ear mold, per year, when the client's existing ear mold is damaged or no longer fits the client's ear.

(4) **Repair of hearing aids.** The agency covers two repairs, per hearing aid, per year, when the cost of the repair is less than fifty percent of the cost of a new hearing aid. To receive payment, all of the following must be met:

(a) All warranties are expired; and

(b) The repair is under warranty for a minimum of ninety days.

(5) **Repair or replacement of external components of cochlear devices and bone-anchored hearing aids.** The agency covers the following with PA.

(a) Repair or replacement of external components of cochlear devices. If the client has bilateral cochlear devices, both devices are eligible for repair and replacement of external components; and

(b) Repair or replacement of external components of bone-anchored hearing aids, whether implanted or worn with a headband. If the client has bilateral bone-anchored hearing aids, both devices are eligible for repair and replacement of external components.

(6) **Rental of hearing aids.** The agency covers rental hearing aid(s) for up to two months while the client's own hearing aid(s) is being repaired. For rental hearing aid(s) only, the agency pays separately for an ear mold(s).

(7) **Second hearing aid.** The agency pays for a second hearing aid when the client either meets the following expedited prior authorization clinical criteria or PA for a limitation extension is requested:

(a) The client tries one hearing aid for a six-month period, but the hearing aid does not adequately meet the client's hearing need; and

(b) One of the following reasons is documented in the client's record:

(i) Inability or difficulty conducting job duties with only one hearing aid;

(ii) Inability or difficulty functioning in the school environment with only one hearing aid; or

(iii) Client is legally blind.

AMENDATORY SECTION (Amending WSR 13-20-013, filed 9/20/13, effective 10/21/13)

WAC 182-547-0900 ((~~Hearing aids—~~))Noncovered services—Clients ((~~twenty years of age and younger~~)) age twenty-one and older. (((~~(1) The agency does not cover the following hearing and hearing aid-related items and services for clients twenty years of age and younger:~~

~~(a) Tinnitus maskers;~~

~~(b) Group screenings for hearing loss, except as provided under the early and periodic screening, diagnosis and treatment (EPSDT) program under WAC 182-534-0100; or~~

~~(c) FM systems, including the computer-aided hearing devices for FM systems.~~

~~(2) When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-534-0100 for EPSDT rules).~~)) (1) The medicaid agency does not cover the following items:

(a) Batteries only for clients age twenty-one and over;

(b) Tinnitus maskers;

(c) Frequency modulation (FM) systems, including the computer-aided hearing devices for FM systems; and

(d) Nonprescription hearing aids or similar devices including, but not limited to:

(i) Personal sound amplification products (PSAPs);

(ii) Hearables; and

(iii) Pocket talkers or similar devices.

(2) The agency evaluates requests for noncovered hearing aids and related services according to WAC 182-501-0160.

AMENDATORY SECTION (Amending WSR 13-20-013, filed 9/20/13, effective 10/21/13)

WAC 182-547-1000 ((~~Hearing aids—~~))Prior authorization—Clients age twenty ((~~years of age~~)) and younger. (1) Prior authorization is not required for clients age twenty ((~~years of age and under~~)) and younger for hearing aid(s) and services. When billing, providers ((~~should~~)) must send claims for clients age twenty ((~~years of age~~)) and younger directly to the medicaid agency. Providers do not have to obtain authorization from the local children with special health care needs (CSHCN) coordinator.

(2) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501-0169.

NEW SECTION

WAC 182-547-1050 Prior authorization—Clients age twenty-one and older. (1) For covered services that require prior authorization (PA), the provider must properly request authorization in accordance with the medicaid agency's rules and billing instructions.

(2) The agency evaluates requests for covered services that are subject to limitations or other restrictions and considers such services beyond those limitations or restrictions as described in WAC 182-501-0169.

(3) When the agency authorizes hearing aids or hearing aid-related services, the PA indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for covered services at the time those services are provided.

(4) To receive payment, providers must order and dispense hearing aids and hearing aid-related services within the authorized time frame.

AMENDATORY SECTION (Amending WSR 13-20-013, filed 9/20/13, effective 10/21/13)

WAC 182-547-1100 ((~~Hearing aids—Reimbursement—General.~~)) Reimbursement. (1) The medicaid agency's payment for purchased hearing aids includes all of the following:

(a) ((~~A prefitting~~)) The audiometric evaluation;

(b) An impression for an ear mold;

(c) The ear mold; ((~~and~~

~~(e) A minimum of three post-fitting consultations.~~))

(d) The dispensing fee;

(e) A conformity evaluation, if done;

(f) Three batteries; and

(g) Up to three follow-up visits for the fitting, orientation, and checking of the hearing aid.

(2) The agency denies payment for hearing aids ((~~and/or~~)) and services when claims are submitted without the prior authorization number, when required, or the appropriate diagnosis or procedure code(s).

(3) The agency does not pay for hearing aid charges paid by insurance or other payer source.

(4) To receive payment, the provider must keep documentation in the client's medical file to support the medical necessity for the specific make and model of the hearing aid ordered for the client. This documentation must include the record of the audiology testing providing evidence that the client's hearing loss meets the eligibility criteria for a hearing aid.

WSR 19-14-125
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE
[Filed July 3, 2019, 11:40 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-06-001 on February 20, 2019.

Title of Rule and Other Identifying Information: New WAC 220-640-011 Failure to stop at mandatory AIS check station—Infraction and 220-640-051 Lawful possession of dead prohibited level 3 species for personal or commercial use; and amending WAC 220-640-030 Prohibited level 1 species and 220-640-050 Prohibited level 3 species.

Hearing Location(s): On September 13-14, 2019, at 8:00 a.m., at the Sun Mountain Lodge, 604 Patterson Lake Road, Winthrop, WA 98862.

Date of Intended Adoption: September 16, 2019.

Submit Written Comments to: Scott Bird, Washington Department of Fish and Wildlife (WDFW), Rules Coordinator, P.O. Box 43200, Olympia, WA 98504-3200, email Rules.Coordinator@dfw.wa.gov, fax 360-902-2155, by September 10, 2019.

Assistance for Persons with Disabilities: Contact Delores Noyes, phone 360-902-2349, TTY 360-902-2207, email Dolores.Noyes@dfw.wa.gov, by September 10, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department needs to clarify regulations for the public concerning the possession of aquatic invasive species and inspection of vessels and boating equipment to check for harmful aquatic invasive species under chapter 220-640 WAC.

Reasons Supporting Proposal: The department needs to better clarify some of the regulations concerning the prohibition of aquatic invasive species.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.04.055, 77.12.045, and 77.12.047.

Statute Being Implemented: RCW 77.04.012, 77.04.020, 77.04.055, 77.12.045, and 77.12.047.

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

Name of Proponent: WDFW, governmental.

Name of Agency Personnel Responsible for Drafting: Captain Eric Anderson, 1111 Washington Street S.E., Olympia, WA 98501, 360-640-0493; Implementation: Allen Pleus, 1111 Washington Street S.E., Olympia, WA 98501, 360-902-2724; and Enforcement: Chief Steve Bear, 1111 Washington Street S.E., Olympia, WA 98501, 360-902-2373.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This rule proposal does not affect hydraulics.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rules will have no impact on small business and less than minor costs.

A copy of the detailed cost calculations may be obtained by contacting Captain Eric Anderson, 1111 Washington Street S.E., Olympia, WA 98501, phone 360-640-0493, fax 360-249-1229, email Eric[.]Anderson@dfw.wa.gov.

July 3, 2019
Scott Bird
Rules Coordinator

NEW SECTION

WAC 220-640-011 Failure to stop at mandatory AIS check station—Infraction. Any person who fails to stop at a mandatory check station is guilty of a gross misdemeanor under RCW 77.15.809; however, if a person has never been previously issued either a citation or warning for this violation, the violation may be issued as an infraction under RCW 77.15.160.

NEW SECTION

WAC 220-640-051 Lawful possession of dead prohibited level 3 species for personal or commercial use—Allowable forms—Records required. (1) It is lawful to possess dead prohibited level 3 species for human or animal consumption use. For purpose of this rule, "dead" is defined as the following forms:

(a) Fully cooked;

(b) Frozen solid;

(c) Canned or otherwise vacuum-sealed in a container;

(d) Preserved by drying, salting, or pickling; or

(e) Raw/fresh if the head has been removed and/or all the internal organs have been removed.

(2) The person or commercial entity must possess the following records upon receiving and while in possession of a prohibited level 3 species in a dead form:

(a) The records must be in accordance with RCW 77.15.568; and

(b) The records must identify:

(i) Taxonomic species name or subspecies name to distinguish the subspecies from another prohibited species or a regulated type A species; and

(ii) The dead form in which the species was received as listed under subsection (1) of this section.

(3) It is unlawful for any person or commercial entity to receive or possess any live prohibited level 3 species or that does not meet the requirements of subsection (1) of this section.

(4) Any person or commercial entity in possession of a prohibited level 3 species violating this regulation shall be guilty of unlawful use of invasive species in the second degree under RCW 77.15.809.

AMENDATORY SECTION (Amending WSR 18-16-042, filed 7/25/18, effective 8/25/18)

WAC 220-640-030 Prohibited level 1 species. The following species are classified as prohibited level 1 species:

(1) Molluscs: Family Dreissenidae: Zebra and quagga mussels: Dreissena polymorpha and Dreissena rostriformis bugensis.

(2) Crustaceans:

(a) Family Grapsidae: Mitten crabs: All members of the genus Erochier.

(b) Family Portunidae: European green crab, Carcinus maenas.

(3) Fish:

(a) Family Channidae: China fish, snakeheads: All members of the genus Channa.

(b) Family Clarriidae: All members of the walking catfish family.

(c) Family Cyprinidae:

(i) Carp, Bighead, Hypopthalmichthys nobilis.

(ii) Carp, Black, Mylopharyngodon piceus.

(iii) Carp, Silver, Hypopthalmichthys molitrix.

(iv) Carp, Largescale Silver, Hypopthalmichthys harmandi.

(d) Family Esocidae: Northern pike, Esox Lucius.

AMENDATORY SECTION (Amending WSR 18-16-042, filed 7/25/18, effective 8/25/18)

WAC 220-640-050 Prohibited level 3 species. The following species are classified as prohibited level 3 species:

(1) Amphibians:

(a) In the family Hylidae: Cricket frog, in the genus Hyla species in the group Arborea including: Hyla annectans, Hyla arborea, Hyla chinensis, Hyla hallowellii, Hyla immaculata, Hyla japonica, Hyla meridionalis, Hyla sanchiangensis, Hyla simplex, Hyla suweonensis, Hyla tsinlingensis, and Hyla zhaopingensis.

(b) In the family Pelobatidae, spadefoots, all species of the genus Pelobates including P. cultripes, P. fuscus, P. syriacus, and P. varaldii. All species of the genus Scaphiopus including: S. couchii, S. holbrookii, and S. hurterii. All species of the genus Spea including: S. bombifrons, S. hammondii, and S. multiplicata with the exception of the native species: Spea intermontana the great basin spadefoot.

(c) In the family Pipidae: African clawed frog, all members of the genera Silurana, and Xenopus.

(d) In the family Ranidae:

(i) American Bull frog, Rana (Lithobates) catesbeiana.

(ii) Holoarctic brown frogs and Palearctic green frogs of the genus Rana, including the following: Rana arvalis group (R. arvalis, R. chaochiaoensis, R. chevronta); Rana chensinensis group (R. altaica, R. chensinensis, R. dybowskii, R. kukunoris, R. kunyuensis, R. ornativentris, R. pirica); Rana graeca group (R. graeca, R. italica); Rana japonica group (R. amurensis, R. aragonensis, R. japonica, R. omeimontis, R. zhenhaiensis); the subgenus Rugosa (Rana rugosa, Rana emeljanovi, Rana tientaiensis); Rana tagoi group (R. sakuraii, R. tagoi); Rana temporaria group (R. asiatica, R. dalmatina, R. honnorate, R. huanrenensis, R. iberica, R. latastei, R. macrocnemis, R. okinavana, R. pyrenaica, R. tsushimensis, R. zhengi); and in the Rana Pelophylax section, the subgenus Pelophylax (R. bedriagae, R. bergeri, R. cerigensis, R. chosenica, R. cretensis, R. demarchii, R. epeirotica, R. fukienensis, R. grafti, R. hubeiensis, R. lateralis, R. lessonae, R. nigrolineata, R. nigromaculata, R. perezi, R. plancyi, R. porosa, R. ridibunda, R. saharica, R. shqiperica, R. shuchinae, R. terentievi, R. tenggerensis); and the Rana ridibunda-Rana lessonae hybridogenetic complex species R. esculenta and R. hispanica.

(e) In the family Ambystomatidae: Mole salamanders. In the genus Ambystomata: A. californiense, A. laterale, A. opacum, A. rosaceum, A. tigrinum, except for the native species A. tigrinum mavortium Western tiger salamander, and A. tigrinum melanostictum Tiger salamander.

(f) In the family Amphiumidae one, two, and three toed salamanders or congo eels: All members of the genus Amphiuma.

(g) In the family Cryptobranchidae: Giant salamanders and hellbenders, all members of the genera Andrias and Cryptobranchus.

(h) In the family Dicamptodontidae, American giant salamanders, all members of the genus Dicamptodon, except for the native species: Dicamptodon tenebrosus, Pacific giant salamander, and Dicamptodon copei, Cope's giant salamander.

(i) In the family Hynobiidae: Mountain salamanders, all members of the genera Batrachuperus, Hynobius, Liua, Onychodactylus, Pachyhynobius, Pseudohynobius, Ranodon, and Salamandrella.

(j) In the family Plethodontidae, subfamily Desmognathinae: All members of the genus Desmognathus, dusky salamander.

(k) In the family Plethodontidae, subfamily Plethodontinae: All members of the genera Eurycea (American brook salamanders); Gyrinophilus (cave salamanders); Hemidactylium (four-toed salamanders); Hydromantes and Pseudotriton (mud or red salamanders).

(l) In the family Proteidae, mudpuppies, all members of the genus Necturus and Proteus.

(m) In the family Salamandridae: Newts, all members of the genera Chioglossa; Eichinotriton (mountain newts); Euproctus (European mt. salamander); Neurergus (Kurdistan newts); Notophthalmus (red-spotted newts); Pachytriton (Chinese newts); Paramesotriton (warty newts); Salamandrina (speckled salamander); Taricha except for the native species Taricha granulosa granulosa the Northern rough-skin newt, and Ichthyosaura and Triturus (alpine newts).

(n) In the family Sirenidae, sirens, all species of the genera Pseudobranchus and Siren.

(2) Reptiles:

(a) In the family Chelydridae, snapping turtles, all species.

(b) In the family Emydidae:

(i) Chinese pond turtles, all members of the genus Chinemys.

(ii) Pond turtles, all members of the genus Clemmys.

(iii) European pond turtle, Emys orbicularis.

(iv) Asian pond turtle, all members of the genus Mauremys.

(c) In the family Trionychidae, American soft shell turtles, all members of the genus Apalone.

(3) Crustaceans:

(a) Family Cercopagidae:

(i) Fish hook water flea, Cercopagis pengoi.

(ii) Spiny water flea, Bythotrephes cederstroemi.

(b) Family Cambaridae: Crayfish: All genera.

(c) Family Parastacidae: Crayfish: All genera except Engaeos, and except the species Cherax quadricarinatus, Cherax papuanus, and Cherax tenuimanus.

(d) Family Spheromatidae: Burrowing isopod, Sphaeroma quoyanum.

(4) Fish:

(a) Family Amiidae: Bowfin, grinnel, or mudfish, Amia calva.

(b) Family Characidae: Piranha or caribe: All members of the genera Pygocentrus, Rooseveltiella, and Serrasalmus.

(c) Family Cyprinidae:

(i) Fathead minnow, Pimephales promelas.

(ii) Carp, Grass (in the diploid form), Ctenopharyngodon idella.

(iii) Ide, silver orfe or golden orfe, Leuciscus idus.

(iv) Rudd, Scardinius erythropthalmus.

(d) Family Gobiidae: Round goby, Neogobius melanostomus.

(e) ((~~Family Esocidae: Northern pike, Esox lucius.~~

~~(f)~~)) Family Lepisosteidae: Gar-pikes: All members of the family.

(5) Mammals: Family Myocastoridae: Nutria, Myocastor coypu.

(6) Molluscs:

(a) Family Dreissenidae: All members of the genus Dreissenid except the species zebra mussel, Dreissena polymorpha, and the quagga mussel, Dreissena rostriformis bugensis.

(b) Family Gastropoda: New Zealand mud snail, Potamopyrgus antipodarum.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This rule does not affect hydraulics.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

July 3, 2019
Scott Bird
Rules Coordinator

WSR 19-14-126
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE

[Filed July 3, 2019, 11:40 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-11-128 on May 22, 2019.

Title of Rule and Other Identifying Information: The department needs to change its rules concerning the Columbia River salmon and steelhead endorsement (CRSSE) to conform to state law.

Hearing Location(s): On September 13-14, 2019, at 8:00 a.m., at the Sun Mountain Lodge, 604 Patterson Lake Road, Winthrop, WA 98862.

Date of Intended Adoption: September 16, 2019.

Submit Written Comments to: Scott Bird, 600 Capitol Way North, Olympia, WA 98501, email [phone] 360-902-2403, fax 360-902-2162, by September 10, 2019.

Assistance for Persons with Disabilities: Contact Delores Noyes, phone 360-902-2349, TTY 360-902-2207, email Delores.Noyes@dfw.wa.gov by September 10, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department needs to amend rules in order to conform to state law.

Reasons Supporting Proposal: Based on the expiration of RCW 77.12.712, 77.12.714, and 77.15.718 concerning CRSSE, the department must amend its existing rules to conform to state law.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.055, 77.12.240, 77.12.800, 77.32.090, 77.32.470.

Statute Being Implemented: RCW 77.04.012, 77.04.055, 77.12.240, 77.12.800, 77.32.090, 77.32.470.

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

Name of Proponent: [Washington department of fish and wildlife], governmental.

Name of Agency Personnel Responsible for Drafting: Deirdre Bissonnette, 1111 Washington Street, Olympia, WA 98501, 360-902-2211; Implementation: Jenika Stinkeoway, 1111 Washington Street, Olympia, WA 98501, 360-902-2304; and Enforcement: Chief Steve Bear, 1111 Washington Street, Olympia, WA 98501, 360-902-6428.

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

WAC 220-220-060 Reduced rate annual fish Washington license, and license upgrades. (1) There is hereby created an annual fish Washington license for residents that combines recreational freshwater and saltwater fishing, shellfish, and seaweed harvest privileges. The fee for the annual fish Washington license is $60.50 and applicable fees as of July 1, 2019, and will not be priced higher than the sum of the individual items. The fish Washington license also includes the following:

(a) ((~~The Columbia River salmon and steelhead endorsement;~~

~~(b)~~)) A Puget Sound Dungeness Crab endorsement; and

(((~~(c)~~))) (b) A two-pole endorsement.

(2) The director is authorized to allow any Washington state resident who has purchased an annual freshwater, saltwater, or shellfish/seaweed license to upgrade to a combination license for the cost difference between his or her current annual fishing license(s) and the cost of the combination license, plus transaction and dealer fees. The director may limit the times of the year that this upgrade is made available for sale.

(3) There is hereby created an annual senior combination recreation fishing license which includes freshwater and saltwater fishing, shellfish, and seaweed harvest privileges. The state fee for the annual senior combination fishing license will not be priced higher than the sum of the individual items and is available to any senior residents.

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

WAC 220-220-230 Free fishing weekend. The Saturday and Sunday following the first Monday in June is declared to be free fishing weekend in Washington. On this weekend a fishing license is not required for any person, regardless of age or residency, to fish for or possess fish and shellfish and a fish and wildlife lands vehicle use permit is not required to utilize department parking facilities except that it is unlawful to fish for or possess any species for which a catch record is required without a valid catch record card in possession. Anglers may fish with two poles in all lakes where it is legal to do so without purchasing a two-pole endorsement((~~, and may also fish in all open areas of the Columbia River and tributaries without purchasing a Colum-~~

~~bia River endorsement~~)). During free fishing weekend only the license, endorsements, and permit provided for in this section are affected, and all other rules including the catch record card requirement remain in effect.

AMENDATORY SECTION (Amending WSR 18-19-021, filed 9/11/18, effective 10/12/18)

WAC 220-220-320 Recreational license dealer's fees. The department and license dealers may charge a license issuance fee as follows:

(1) Two dollars for the issuance of any of the following fishing licenses:

(a) A combination license.

(b) A saltwater license.

(c) A freshwater license.

(d) A one-, two-, or three-day temporary fishing license.

(e) A family fishing weekend license.

(f) A shellfish and seaweed license.

(g) A razor clam license.

(2) Two dollars for the issuance of any of the following hunting licenses:

(a) A big game combination license.

(b) A small game license.

(c) A three-consecutive day small game license.

(d) A hunter education deferral for a big game license.

(e) A hunter education deferral for a small game license.

(f) A second animal license.

(g) A special hunt license for mountain goat, bighorn sheep, or moose.

(h) A Western Washington pheasant license.

(i) A three-day Western Washington pheasant license.

(3) Notwithstanding the provisions of this section, if any two or more licenses are issued at the same time, or the fish and wildlife lands vehicle access pass is issued with any recreational license, the license issuance fee for the document is two dollars.

(4) Two dollars for the issuance of an annual discover pass.

(5) Two dollars for the issuance of an aquatic invasive species prevention permit.

(6) Fifty cents for the issuance of any of the following:

(a) A deer, elk, bear, cougar, mountain goat, mountain sheep, moose, or turkey transport tag.

(b) An application for a special permit hunt.

(c) Migratory bird harvest report cards issued with a hunt authorization.

(d) A replacement of substitute special hunting season permit.

(e) A migratory bird permit.

(f) Additional fishing catch record cards.

(g) A Puget Sound crab endorsement.

(h) A temporary Puget Sound crab endorsement.

(i) A two-pole endorsement.

(j) ((~~A Columbia River salmon/steelhead endorsement. (k)~~)) A one-day discover pass.

(((~~(l)~~))) (k) Raffle tickets.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-220-210 Columbia River endorsement.

WSR 19-14-127
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE

[Filed July 3, 2019, 11:42 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-09-081 on April 17, 2019.

Title of Rule and Other Identifying Information: The department seeks to create a new rule which addresses the accounting of funds for the sale of packaged recreational licenses that were created after January 1, 2017.

Hearing Location(s): On September 13-14, 2019, at 8:00 a.m., at the Sun Mountain Lodge, 604 Patterson Lake Road, Winthrop, WA 98862.

Date of Intended Adoption: September 16, 2019.

Submit Written Comments to: Scott Bird, 600 Capitol Way North, Olympia, WA 98501, email [phone] 360-902-2403, fax 360-902-2162, by September 10, 2019.

Assistance for Persons with Disabilities: Contact Delores Noyes, phone 360-902-2349, TTY 360-902-2207, email Delores.Noyes@dfw.wa.gov, by September 10, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department wants to improve the reconciliation of its sales from discount and packaged licenses.

Reasons Supporting Proposal: The department needs to clarify the accounting of funds received from the sales of all discount and packaged recreational licenses.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.055, 77.12.240, 77.12.800, 77.32.090, and 77.32.470.

Statute Being Implemented: RCW 77.04.012, 77.04.055, 77.12.240, 77.12.800, 77.32.090, and 77.32.470.

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

Name of Proponent: [Washington department of fish and wildlife], governmental.

Name of Agency Personnel Responsible for Drafting: Deirdre Bissonnette, 1111 Washington Street, Olympia, WA 98501, 360-902-2211; Implementation: Jenika Stinkeoway, 1111 Washington Street, Olympia, WA 98501, 360-902-2304; and Enforcement: Chief Steve Bear, 1111 Washington Street, Olympia, WA 98501, 360-902-6428.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This rule does not affect hydraulics.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

July 3, 2019
Scott Bird
Rules Coordinator

NEW SECTION

WAC 220-220-095 Discount distribution. When a recreational license is sold at a discount or when it is part of a package of licenses created after January 1, 2017, and sold at a price less than the total value of each individual license product, the funds from the sale of a license or package of licenses are distributed to multiple department accounts. The amount of the funds distributed to each of the accounts shall be reduced by the same percentage as the total discount for the purchase of a license or package commencing with license year 2020 products.

WSR 19-14-128
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE

[Filed July 3, 2019, 11:47 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-11-127 on May 22, 2019.

Title of Rule and Other Identifying Information: New WAC designed to create a combined hunting and fishing package in chapter 220-220 WAC for Washington residents.

Hearing Location(s): On September 13-14, 2019, at 8:00 a.m., at the Sun Mountain Lodge, 604 Patterson Lake Road, Winthrop, WA 98862.

Date of Intended Adoption: On or after September 16, 2019.

Submit Written Comments to: Scott Bird, Washington Department of Fish and Wildlife (WDFW) Rules Coordinator, P.O. Box 43200, Olympia, WA 98504-3200, email Rules.Coordinator@dfw.wa.gov, fax 360-902-2155, by September 10, 2019.

Assistance for Persons with Disabilities: Contact Dolores Noyes, phone 360-902-2349, TTY 360-902-2207, by September 10, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the new recreational package is to increase convenience and reduce cost for individuals in the public who may want to hunt and fish by purchasing one annual package.

Reasons Supporting Proposal: The new rule promotes both cost savings and convenience to individuals who hunt and fish in the state.

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

Statute Being Implemented: RCW 77.04.012, 77.04.020, 77.04.055, 77.12.045, and 77.12.047.

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

Name of Proponent: WDFW, governmental.

Name of Agency Personnel Responsible for Drafting: Deidre Bissonnette, 1111 Washington Street S.E., Olympia, WA 98501, 360-902-2211; Implementation: Jenika Stinkeoway, 1111 Washington Street S.E., Olympia, WA 98501, 360-902-2304; and Enforcement: Chief Steve Bear, 1111 Washington Street S.E., Olympia, WA 98501, 360-902-2373.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. No hydraulics are involved in this rule making.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. There is less than minor costs on small business[es] associated with the adoption of this new rule.

A copy of the detailed cost calculations may be obtained by contacting Deidre Bissonnette, 1111 Washington Street S.E. Olympia, WA 98501, phone 360-902-2211, email Deidre.Bissonnette@dfw.wa.gov.

July 3, 2019
Scott Bird
Rules Coordinator

NEW SECTION

WAC 220-220-093 Combination hunting and fishing packages. There is hereby created an annual Get Outdoors license for residents that combines fishing, shellfishing, and hunting privileges. The fee for the annual Get Outdoors license will not be priced higher than the sum of the individual items. The fee for this license is $208.80 and applicable fees as of December 1, 2019.

The Get Outdoors license includes the following:

(1) Annual combination recreational freshwater, saltwater, and shellfish license as described in WAC 220-220-060;

(2) Two-pole endorsement as described in WAC 220-220-160;

(3) Puget Sound Dungeness crab endorsement as described in WAC 220-310-020;

(4) Annual combination hunting license for deer, elk, bear, and cougar as described in RCW 77.32.450;

(5) Small game license as described in RCW 77.32.460;

(6) Migratory bird permit and migratory bird authorization as described in RCW 77.32.350 and WAC 220-412-100; and

(7) Two turkey tags as described in RCW 77.32.460.