Chapter 48.20 RCW
DISABILITY INSURANCE

Sections

Approval of policy forms: RCW 48.18.100.

Assignment of policies: RCW 48.18.360.

Exemption of proceeds: RCW 48.18.400.

General provisions regarding filing, approval, contents of policies, execution, applications, etc.: Chapter 48.18 RCW.

Grounds for disapproval of policy forms: RCW 48.18.110.

Insurable interest, personal insurance, nonprofit organizations: RCW 48.18.030.

Minimum standard conditions and terminology for disability policies, established by commissioner: RCW 48.18.120(2).

Minor contracting for life or disability insurance: RCW 48.18.020.

Payment to person designated in policy or by assignment discharges insurer: RCW 48.18.370.

Rates, manuals, classifications—Filing: RCW 48.19.010(2).

Refusal to renew or cancellation of disability insurance: RCW 48.18.298, 48.18.299.

RCW 48.20.002 Scope of chapter. Nothing in this chapter shall apply to or affect (1) any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or (2) any policy or contract of reinsurance; or (3) any blanket or group policy of insurance; or (4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract. [1987 c 185 § 25; 1951 c 229 § 1.]

Reviser's note: For prior laws governing standard provision requirements for individual accident or health insurance policies see 1947 c 79 §§ .20.01 through .20.33 and .20.37 and Rem. Supp. 1947 §§ 45.20.01 through 45.20.33 and 45.20.37.

Many of the sections enacted in 1951 c 229 are in substance amendatory of sections previously appearing in chapter 48.20 RCW, although they appear in 1951 c 229 as new sections. To assist those using the code, the prior enactment on the same subject is shown in the history note following the new section wherever practical.

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

RCW 48.20.012 Format of disability policies. No disability policy shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

(1) It shall purport to insure only one person, except as to family expense insurance written pursuant to RCW 48.20.340.

(2) The style, arrangement and over-all appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or

attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and caption and subcaptions).

(3) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in RCW 48.20.042 to *48.20.272, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(4) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(5) It shall contain no provision purporting to make any portion of the insurer's charter, rules, constitution, or bylaws a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner. [1951 c 229 § 2; 1947 c 79 § .20.02; formerly Rem. Supp. 1949 § 45.20.02.]

***Reviser's note:** RCW 48.20.272 was repealed by 2004 c 112 § 6.

RCW 48.20.013 Return of policy and refund of premium—Notice required—Effect of return. Every individual disability insurance policy issued after January 1, 1968, except single premium nonrenewable policies, shall have printed on its face or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten days of its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy to the insurer or insurance producer. If a policyholder or purchaser pursuant to such notice, returns the policy to the insurer at its home or branch office or to the insurance producer through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. [2008 c 217 § 21; 1983 1st ex.s. c 32 § 9; 1967 c 150 § 26.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.20.015 Endorsements. If a contract is issued on any basis other than as applied for, an endorsement setting forth such modification(s) must accompany and be attached to the policy; and no endorsement shall be effective unless signed by the policyowner, and a

signed copy thereof returned to the insurer. [1975 1st ex.s. c 266 § 9.]

Severability—1975 1st ex.s. c 266: See note following RCW 48.01.010.

RCW 48.20.022 Policies issued by domestic insurer for delivery in another state. If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public official of such other state has advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the applicable standards set forth in this chapter and in chapter 48.18 RCW. [1951 c 229 § 3.]

RCW 48.20.025 Schedule of rates for individual health benefit plans—Loss ratio—Definitions. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the insurer of health care services, as defined in RCW 48.43.005, provided to a policyholder or paid to or on behalf of the policyholder in accordance with the terms of a health benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for a policyholder.

(b) "Claims reserves" means: (i) The liability for claims which have been reported but not paid; (ii) the liability for claims which have not been reported but which may reasonably be expected; (iii) active life reserves; and (iv) additional claims reserves whether for a specific liability purpose or not.

(c) "Declination rate" for an insurer means the percentage of the total number of applicants for individual health benefit plans received by that insurer in the aggregate in the applicable year which are not accepted for enrollment by that insurer based on the results of the standard health questionnaire administered pursuant to *RCW 48.43.018(2)(a).

(d) "Earned premiums" means premiums, as defined in RCW 48.43.005, plus any rate credits or recoupments less any refunds, for the applicable period, whether received before, during, or after the applicable period.

(e) "Incurred claims expense" means claims paid during the applicable period plus any increase, or less any decrease, in the claims reserves.

(f) "Loss ratio" means incurred claims expense as a percentage of earned premiums.

(g) "Reserves" means: (i) Active life reserves; and (ii) additional reserves whether for a specific liability purpose or not.

(2) An insurer must file supporting documentation of its method of determining the rates charged for its individual health benefit plans. At a minimum, the insurer must provide the following supporting documentation:

(a) A description of the insurer's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the insurer's projection;

(c) The percentage of premium attributable in aggregate for nonclaims expenses used to determine the adjusted community rates charged; and

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard of seventy-four percent, minus the premium tax rate applicable to the insurer's individual health benefit plans under RCW 48.14.020. [2011 c 314 § 10; 2008 c 303 § 4; 2003 c 248 § 8; 2001 c 196 § 1; 2000 c 79 § 3.]

***Reviser's note:** RCW 48.43.018 was repealed by 2019 c 33 § 7.

Effective date—2011 c 314 §§ 10-12: "Sections 10 through 12 of this act take effect January 1, 2012." [2011 c 314 § 19.]

Effective date—2001 c 196: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 7, 2001]." [2001 c 196 § 14.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 48.20.028 Calculation of premiums—Adjusted community rating method—Definitions. (1) Premiums for health benefit plans for individuals shall be calculated using the adjusted community rating method that spreads financial risk across the carrier's entire individual product population, except the individual product population covered under RCW 48.20.029. All such rates shall conform to the following:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.20.029, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045.

(3) As used in this section, "health benefit plan," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

(4) This section shall not apply to premiums for health benefit plans covered under RCW 48.20.029. [2006 c 100 § 1; 2000 c 79 § 4; 1997 c 231 § 207; 1995 c 265 § 13.]

***Reviser's note:** RCW 48.43.015 was repealed by 2019 c 33 § 7.

Legality of purchasing pools—Federal opinion requested—2006 c 100: "No policy or contract may be solicited, or contribution collected under this act until a federal opinion is received by the insurance commissioner indicating whether the purchasing pools referenced in sections 2, 4, and 6 of this act are legal. The commissioner shall request such an opinion from the federal departments of labor, treasury, health and human services, or other appropriate federal agencies no later than August 1, 2006. Upon receipt, the commissioner shall forward the opinion to the legislature, and within thirty days, provide the legislature with a report assessing the legality and potential impact of these purchasing pools on the uninsured and insurance markets in Washington state." [2006 c 100 § 7.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Short title—Part headings and captions not law—Severability—Effective dates—1997 c 231: See notes following RCW 48.43.005.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.20.029 Calculation of premiums—Members of a purchasing pool—Adjusted community rating method—Definitions. (1) Premiums for health benefit plans for individuals who purchase the plan as a member of a purchasing pool:

(a) Consisting of five hundred or more individuals affiliated with a particular industry;

(b) To whom care management services are provided as a benefit of pool membership; and

(c) Which allows contributions from more than one employer to be used towards the purchase of an individual's health benefit plan; shall be calculated using the adjusted community rating method that spreads financial risk across the entire purchasing pool of which the individual is a member. All such rates shall conform to the following:

(i) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(A) Geographic area;

(B) Family size;

(C) Age;

(D) Tenure discounts; and

(E) Wellness activities.

(ii) The adjustment for age in (c)(i)(C) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(iii) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer, and coverage for which medicare is not the primary payer. Both rates are subject to the requirements of this subsection.

(iv) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(v) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(vi) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(A) Changes to the family composition;

(B) Changes to the health benefit plan requested by the individual; or

(C) Changes in government requirements affecting the health benefit plan.

(vii) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(viii) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045.

(3) As used in this section, "health benefit plan," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 2.]

***Reviser's note:** RCW 48.43.015 was repealed by 2019 c 33 § 7.

Legality of purchasing pools—Federal opinion requested—2006 c 100: See note following RCW 48.20.028.

RCW 48.20.032 Standard provisions required—Substitutions—Captions. Except as provided in RCW 48.18.130, each such policy delivered or issued for delivery to any person in this state shall contain the provisions as specified in RCW 48.20.042 to 48.20.152, inclusive, in the words in which the same appear; except, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded by the applicable caption shown or, at the insurer's option, by such appropriate individual or group caption or subcaption as the commissioner may approve. [1951 c 229 § 4; 1947 c 79 § .20.03; formerly Rem. Supp. 1947 § 45.20.03.]

RCW 48.20.042 Standard provision No. 1—Entire contract; changes. There shall be a provision as follows:

ENTIRE CONTRACTS; CHANGES: This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions. [2008 c 217 § 22; 1951 c 229 § 5. Prior law: (i) 1947 c 79 § .20.05; Rem. Supp. 1947 § 45.20.05. (ii) 1947 c 79 § .20.06; Rem. Supp. 1947 § 45.20.06.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.20.050 Standard provision No. 2—Misstatement of age or sex. There shall be a provision as follows:

"MISSTATEMENT OF AGE OR SEX: If the age or sex of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age or sex."

The amount of any underpayments which may have been made on account of any such misstatement under a disability income policy shall be paid the insured along with the current payment and the amount of any overpayment may be charged against the current or succeeding payments to be made by the insurer. Interest may be applied to such underpayments or overpayments as specified in the insurance policy form but not exceeding six percent per annum. [1983 1st ex.s. c 32 § 16.]

RCW 48.20.052 Standard provision No. 3—Time limit on certain defenses. There shall be a provision as follows:

"TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of RCW 48.20.050, 48.20.172, 48.20.192, 48.20.202, and 48.20.212 in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.")

"(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(More stringent provisions may be required by the commissioner in connection with individual disability policies sold without any application or with minimal applications.) [1983 1st ex.s. c 32 § 17; 1975 1st ex.s. c 266 § 12; 1973 1st ex.s. c 152 § 4; 1969 ex.s. c 241 § 12; 1951 c 229 § 6.]

Severability—1975 1st ex.s. c 266: See note following RCW 48.01.010.

Severability—1973 1st ex.s. c 152: See note following RCW 48.05.140.

RCW 48.20.062 Standard provision No. 4—Grace period. There shall be a provision as follows:

GRACE PERIOD: A grace period of . . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies, and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision: "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision: "Unless

not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his or her last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.") [2009 c 549 § 7096; 1951 c 229 § 7.]

RCW 48.20.072 Standard provision No. 5—Reinstatement. There shall be a provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: PROVIDED, HOWEVER, That if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.) [2008 c 217 § 23; 1951 c 229 § 8; 1947 c 79 § .20.07; formerly Rem. Supp. 1947 § 45.20.07.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.20.082 Standard provision No. 6—Notice of claim. There shall be a provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at . . . . . (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he or she shall at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.") [2009 c 549 § 7097; 1951 c 229 § 9. Prior law: 1947 c 79 § .20.08; Rem. Supp. 1947 § 45.20.08.]

RCW 48.20.092 Standard provision No. 7—Claim forms. There shall be a provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, the character and the extent of the loss for which claim is made. [1951 c 229 § 10; 1947 c 79 § .20.10; formerly Rem. Supp. 1947 § 45.20.10.]

Furnishing claim forms does not constitute waiver of any defense by insurer: RCW 48.18.470.

Insurer has no responsibility as to completion of claim forms: RCW 48.18.460.

RCW 48.20.102 Standard provision No. 8—Proofs of loss. There shall be a provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. [1951 c 229 § 11. Prior: (i) 1947 c 79 § .20.11; Rem. Supp. 1947 § 45.20.11. (ii) 1947 c 79 § .20.09, part; Rem. Supp. 1947 § 45.20.09, part.]

RCW 48.20.112 Standard provision No. 9—Time of payment of claims. There shall be a provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any

periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. [1951 c 229 § 12. Prior: (i) 1947 c 79 § .20.13; Rem. Supp. 1947 § 45.20.13. (ii) 1947 c 79 § .20.14; Rem. Supp. 1947 § 45.20.14.]

RCW 48.20.122 Standard provision No. 10—Payment of claims. (1) There shall be a provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(2) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $. . . . . (insert an amount which shall not exceed $1000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

"Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person." [1951 c 229 § 13. Prior: 1947 c 79 § .20.15; Rem. Supp. 1947 § 45.20.15.]

Proceeds of disability policy are exempt from creditors: RCW 48.18.400.

RCW 48.20.132 Standard provision No. 11—Physical examination and autopsy. There shall be a provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law. [1951 c 229 § 14. Prior: 1947 c 79 § .20.12; Rem. Supp. 1947 § 45.20.12.]

RCW 48.20.142 Standard provision No. 12—Legal actions. There shall be a provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. [1951 c 229 § 15. Prior: 1947 c 79 § . 20.18; Rem. Supp. 1947 § 45.20.18.]

RCW 48.20.152 Standard provision No. 13—Change of beneficiary. There shall be a provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.) [1951 c 229 § 16. Prior: 1947 c 79 § .20.17; Rem. Supp. 1947 § 45.20.17.]

RCW 48.20.162 Optional standard provisions. Except as provided in RCW 48.18.130, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in RCW 48.20.172 to *48.20.272, inclusive, unless such provisions are in the words in which the same appear in the applicable section; except, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption or, at the insurer's option, by such appropriate individual or group caption or subcaption as the commissioner may approve. [1951 c 229 § 17. Prior: 1947 c 79 § .20.20; Rem. Supp. 1947 § 45.20.20.]

***Reviser's note:** RCW 48.20.272 was repealed by 2004 c 112 § 6.

RCW 48.20.172 Optional standard provision No. 14—Change of occupation. There may be a provision as follows:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his or her occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of

occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation. [2009 c 549 § 7098; 1951 c 229 § 18.]

RCW 48.20.192 Optional standard provision No. 15—Other insurance in this insurer. There may be a provision as follows:

OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for . . . . . (insert type of coverage or coverages) in excess of $. . . . . (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his or her beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies. [2009 c 549 § 7099; 1951 c 229 § 20. Prior: 1947 c 79 § .20.24; Rem. Supp. 1947 § 45.20.24.]

RCW 48.20.202 Optional standard provision No. 16—Insurance with other insurers (Provision of service or expense incurred basis). (1) There may be a provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(2) If the foregoing policy provision is included in a policy which also contains the policy provision set out in RCW 48.20.212, there shall be added to the caption of the foregoing provision the phrase ". . . . . expense incurred benefits." The insurer may, at

its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage." [1987 c 185 § 26; 1951 c 229 § 21. Prior: 1947 c 79 § .20.22; Rem. Supp. 1947 § 45.20.22.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

RCW 48.20.212 Optional standard provision No. 17—Insurance with other insurers. (1) There may be a provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(2) If the foregoing policy provision is included in a policy which also contains the policy provision set out in RCW 48.20.202, there shall be added to the caption of the foregoing provision the phrase ". . . . . other benefits." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid

coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage." [1987 c 185 § 27; 1951 c 229 § 22. Prior: 1947 c 79 § .20.22; Rem. Supp. 1947 § 45.20.22.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

RCW 48.20.222 Optional standard provision No. 18—Relation of earnings to insurance. (1) There may be a provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his or her average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(2) The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (a) until at least age 50 or, (b) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations. [2009 c 549 § 7100; 1987 c 185 § 28; 1951 c 229 § 23.]

Intent—Severability—1987 c 185: See notes following RCW 51.12.130.

RCW 48.20.232 Optional standard provision No. 19—Unpaid premium. There may be a provision as follows:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. [1951 c 229 § 24. Prior: 1947 c 79 § .20.23; Rem. Supp. 1947 § 45.20.23.]

RCW 48.20.242 Optional standard provision No. 20—Cancellation. There may be a provision as follows:

CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his or her last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. [2009 c 549 § 7101; 1951 c 229 § 25. Prior: 1947 c 79 § .20.21; Rem. Supp. 1947 § 45.20.21.]

RCW 48.20.252 Optional standard provision No. 21—Conformity with state statutes. There may be a provision as follows:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes. [1951 c 229 § 26.]

RCW 48.20.262 Optional standard provision No. 22—Illegal occupation. There may be a provision as follows:

ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation. [1951 c 229 § 27. Prior: 1947 c 79 § .20.26; Rem. Supp. 1947 § 45.20.26.]

RCW 48.20.282 Order of certain policy provisions. The provisions which are the subject of RCW 48.20.042 to *48.20.272, inclusive, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the insurer's option, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued. [1951 c 229 § 29.]

***Reviser's note:** RCW 48.20.272 was repealed by 2004 c 112 § 6.

RCW 48.20.292 Third party ownership. The word "insured," as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein. [1951 c 229 § 30.]

Insurable interest defined, personal insurance, nonprofit organizations: RCW 48.18.030.

RCW 48.20.302 Requirements of other jurisdictions. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or to the beneficiary than the provisions of this chapter and which is prescribed or required by the laws of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country. [1951 c 229 § 31.]

Domestic insurer may transact insurance in other state as permitted by laws thereof: RCW 48.07.140.

RCW 48.20.312 Age limit. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. [1951 c 229 § 32. Prior: 1947 c 79 § .20.25; Rem. Supp. 1947 § 45.20.25.]

RCW 48.20.340 "Family expense disability insurance" defined. (1) Family expense disability insurance is that covering members of any one family including one or both spouses and dependents provided under a master policy issued to the head of the family.

(2) Any authorized disability insurer may issue family expense disability insurance.

(3) A disability policy providing such family expense coverage, in addition to other provisions required to be contained in disability policies under this chapter, shall contain the following provisions:

(a) A provision that the policy and the application of the head of the family shall constitute the entire contract between the parties.

(b) A provision that to the family group originally insured shall, on notice to the insurer, be added from time to time all new members of the family as they become eligible for insurance in such family group, and on the payment of such additional premium as may be required therefor. [1961 c 194 § 5; 1947 c 79 § .20.34; Rem. Supp. 1947 § 45.20.34.]

RCW 48.20.350 "Franchise plan" defined. (1) Disability insurance on a franchise plan is that issued to

(a) five or more employees of a common employer, or to

(b) ten or more members of any bona fide trade or professional association or labor union, which association or union was formed and exists for purposes other than that of obtaining insurance, and under which such employees or members, with or without their dependents, are issued individual policies which may vary as to amounts and kinds of coverage as applied for, under an arrangement whereby the premiums on the policies are to be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association, or by some designated employee or officer of the association acting on behalf of the employer or association members.

(2) An insurer may charge different rates, provide different benefits, or employ different underwriting procedure for individuals insured under a franchise plan, if such rates, benefits, or procedures as used do not discriminate as between franchise plans, and do not discriminate unfairly as between individuals insured under franchise plans and individuals otherwise insured under similar policies. [1947 c 79 § .20.35; Rem. Supp. 1947 § 45.20.35.]

RCW 48.20.360 Extended disability benefit. A disability insurance contract which provides a reasonable amount of disability indemnity for both accidental injuries and sickness, other than a contract of group or blanket insurance, may provide a benefit in amount not exceeding two hundred dollars payable in event of death from any causes. Such benefit shall be deemed to constitute the payment of disability benefits beyond the period for which otherwise payable, and shall not be deemed to constitute life insurance. [1947 c 79 § .20.36; Rem. Supp. 1947 § 45.20.36.]

RCW 48.20.380 Incontestability after reinstatement. The reinstatement of any policy of noncancellable disability insurance hereafter delivered or issued for delivery in this state shall be contestable only on account of fraud or misrepresentation of facts material to the reinstatement and only for the same period following reinstatement as is provided in the policy with respect to the contestability thereof after the original issuance of the policy. [1947 c 79 § .20.38; Rem. Supp. 1947 § 45.20.38.]

RCW 48.20.385 When injury caused by intoxication or use of narcotics. An insurer may not deny coverage for the treatment of an injury solely because the injury was sustained as a consequence of the

insured's being intoxicated or under the influence of a narcotic. [2004 c 112 § 2.]

Finding—2004 c 112: "The legislature finds that an alcohol or drug-related injury that requires treatment in an emergency department can be a critical moment in the life of a person with a substance abuse problem. Studies have demonstrated that appropriate interventions by hospital staff at these times can reduce substance abuse and lower future health care costs. The perception among health care providers that they may be penalized by insurers for conducting these interventions prevents many of them from performing interventions which can make all the difference to a person at the crossroads of a substance abuse problem." [2004 c 112 § 1.]

Application—2004 c 112: "This act applies to all contracts issued or renewed on or after June 10, 2004." [2004 c 112 § 7.]

RCW 48.20.389 Prescribed, self-administered anticancer medication. (1) Each health plan issued or renewed on or after January 1, 2012, that provides coverage for cancer chemotherapy treatment must provide coverage for prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis at least comparable to cancer chemotherapy medications administered by a health care provider or facility as defined in *RCW 48.43.005 (25) and (26).

(2) Nothing in this section may be interpreted to prohibit a health plan from administering a formulary or preferred drug list, requiring prior authorization, or imposing other appropriate utilization controls in approving coverage for any chemotherapy. [2020 c 18 § 19; 2011 c 159 § 3.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsections (25) and (26) to subsections (27) and (28).

Explanatory statement—2020 c 18: See note following RCW 43.79A.040.

Findings—2011 c 159: See note following RCW 41.05.175.

RCW 48.20.390 Podiatric medicine and surgery. Notwithstanding any provision of any disability insurance contract, benefits shall not be denied thereunder for any medical or surgical service performed by a holder of a license issued pursuant to chapter 18.22 RCW provided that (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW. [1963 c 87 § 1.]

Application—1963 c 87: "This act shall apply to all contracts issued on or after the effective date of this act." [1963 c 87 § 3.]

RCW 48.20.391 Diabetes coverage. The legislature finds that diabetes imposes a significant health risk and tremendous financial

burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and

(b) "Health care provider" means a health care provider as defined in RCW 48.43.005.

(2) All disability insurance contracts providing health care services, delivered or issued for delivery in this state and issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For disability insurance contracts that include pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all disability insurance contracts providing health care services, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the insurer from restricting patients to seeing only health care providers who have signed participating provider agreements with the insurer or an insuring entity under contract with the insurer.

(3) Except as provided in RCW 48.43.780, coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.

(6) The insurer need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.

(7) This section does not apply to the health benefit plan that provides benefits identical to the schedule of services covered by the basic health plan, as required by RCW 48.20.028. [2020 c 346 § 7; 2020 c 245 § 3; 1997 c 276 § 2.]

Reviser's note: This section was amended by 2020 c 245 § 3 and by 2020 c 346 § 7, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Intent—2020 c 346: See note following RCW 70.14.165.

Effective date—1997 c 276: See note following RCW 41.05.185.

RCW 48.20.392 Prostate cancer screening. (1) Each disability insurance policy issued or renewed after December 31, 2006, that provides coverage for hospital or medical expenses shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.

(2) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of an insurer to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. This section shall not apply to medicare supplemental policies or supplemental contracts covering a specified disease or other limited benefits. [2006 c 367 § 2.]

RCW 48.20.393 Mammograms—Insurance coverage. Each disability insurance policy issued or renewed after January 1, 1990, that provides coverage for hospital or medical expenses shall provide coverage for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the *nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

This section shall not be construed to prevent the application of standard policy provisions, other than the cost-sharing prohibition provided in RCW 48.43.076, that are applicable to other benefits. This section does not limit the authority of an insurer to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits. [2023 c 366 § 3; 1994 sp.s. c 9 § 728; 1989 c 338 § 1.]

***Reviser's note:** The reference to "nursing care quality assurance commission" was changed to "board of nursing" by 2023 c 123.

Intent—2023 c 366: See note following RCW 48.43.076.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

RCW 48.20.395 Reconstructive breast surgery. (1) Any disability insurance contract providing hospital and medical expenses and health care services delivered or issued in this state after July 24, 1983, shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.

(2) Any disability insurance contract providing hospital and medical expenses and health care services delivered or issued in this state after January 1, 1986, shall provide coverage for all stages of

one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. [1985 c 54 § 5; 1983 c 113 § 1.]

Effective date—1985 c 54: See note following RCW 48.20.397.

RCW 48.20.397 Mastectomy, lumpectomy. No person engaged in the business of insurance under this chapter may refuse to issue any contract of insurance or cancel or decline to renew the contract solely because of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased, or reduced solely on the basis of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. [1985 c 54 § 1.]

Effective date—1985 c 54: "This act shall take effect January 1, 1986." [1985 c 54 § 9.]

RCW 48.20.410 Optometry. Notwithstanding any provision of any disability insurance contract, benefits shall not be denied thereunder for any eye care service rendered by a holder of a license issued pursuant to chapter 18.53 RCW, provided, that (1) the service rendered was within the lawful scope of such person's license, and (2) such contract would have provided the benefits for such service if rendered by a holder of a license issued pursuant to chapter 18.71 RCW. [1965 c 149 § 2.]

Construction—1965 c 149: "Sections 1 through 3 of this act shall not apply to contracts in force prior to the effective date of this 1965 act, nor to any renewal of such contracts where there has been no change in any provisions thereof." [1965 c 149 § 4.]

RCW 48.20.411 Registered nurses or advanced registered nurses. Notwithstanding any provision of any disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health care service performed by a holder of a license for registered nursing practice or advanced registered nursing practice issued pursuant to chapter 18.79 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1994 sp.s. c 9 § 729; 1973 1st ex.s. c 188 § 3.]

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Severability—1973 1st ex.s. c 188: See note following RCW 48.18.298.

RCW 48.20.412 Chiropractic. Notwithstanding any provision of any disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health care service performed by a holder of a license issued pursuant to chapter 18.25 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1971 ex.s. c 13 § 1.]

RCW 48.20.414 Psychological services. Notwithstanding any provision of any disability insurance contract, benefits shall not be denied thereunder for any psychological service rendered by a holder of a license issued pursuant to chapter 18.83 RCW: PROVIDED, That (1) the service rendered was within the lawful scope of such person's license, and (2) such contract would have provided the benefits for such service if rendered by a holder of a license issued pursuant to chapter 18.71 RCW. [1971 ex.s. c 197 § 1.]

Application—1971 ex.s. c 197: "Sections 1 and 2 of this act shall not apply to any contract in force prior to the effective date of this 1971 act, nor to any renewal of such contract where there has been no change in any provision thereof." [1971 ex.s. c 197 § 3.]

RCW 48.20.416 Dentistry. Notwithstanding any provision of any disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health care service performed by a holder of a license issued pursuant to chapter 18.32 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service has [had] been performed by a holder of a license issued [pursuant] to chapter 18.71 RCW: PROVIDED, HOWEVER, That no provision of chapter 18.71 RCW shall be asserted to deny benefits under this section.

The provisions of this section are intended to be remedial and procedural to the extent they do not impair the obligation of any existing contract. [1974 ex.s. c 42 § 1.]

RCW 48.20.417 Dental services that are not subject to contract or provider agreement. (1) Notwithstanding any other provisions of law, no disability insurance policy of any disability insurer as provided in this chapter subject to the jurisdiction of the state of Washington that covers any dental services, and no contract or participating provider agreement with a dentist may:

(a) Require, directly or indirectly, that a dentist who is a participating provider provide services to a subscriber at a fee set by, or at a fee subject to the approval of, the disability insurer unless the dental services are covered services, including services that would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods, or frequency limitations, under the applicable disability insurance policy; nor

(b) Prohibit, directly or indirectly, a dentist who is a participating provider from offering or providing to a subscriber dental services that are not covered services on any terms or conditions acceptable to the dentist and the subscriber.

(2) For the purposes of this section, "covered services" means dental services that are reimbursable under the applicable insurance policy or subscriber agreement or would be reimbursable but for the application of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods or frequency limitations. [2010 c 228 § 1.]

RCW 48.20.418 Denturist services. Notwithstanding any provision of any disability insurance contract covering dental care as provided for in this chapter, effective January 1, 1995, benefits shall not be denied thereunder for any service performed by a denturist licensed under chapter 18.30 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW. [1995 c 1 § 21 (Initiative Measure No. 607, approved November 8, 1994).]

Short title—1995 c 1 (Initiative Measure No. 607): See RCW 18.30.900.

RCW 48.20.420 Dependent child coverage—Continuation for incapacity. Any disability insurance contract providing health care services, delivered or issued for delivery in this state more than one hundred twenty days after August 11, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract, shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (1) incapable of self-sustaining employment by reason of developmental or physical disability and (2) chiefly dependent upon the subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age. [2020 c 274 § 30; 1985 c 264 § 10; 1969 ex.s. c 128 § 3.]

RCW 48.20.430 Dependent child coverage—From moment of birth—Congenital anomalies—Notification of birth. (1) Any disability insurance contract providing hospital and medical expenses and health

care services, delivered or issued for delivery in this state more than one hundred twenty days after February 16, 1974, which provides coverage for dependent children of the insured, shall provide coverage for newborn infants of the insured from and after the moment of birth. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

(2) If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer. The notification period shall be no less than sixty days from the date of birth. This subsection applies to policies issued or renewed on or after January 1, 1984. [1983 1st ex.s. c 32 § 18; 1974 ex.s. c 139 § 1.]

RCW 48.20.435 Option to cover dependents under age twenty-six. (1) Each disability insurance contract that is not grandfathered and that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six.

(2) Each grandfathered disability insurance contract that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six unless the child is eligible to enroll in an eligible health plan sponsored by the child's employer or the child's spouse's employer.

(3) As used in this section, "grandfathered" has the same meaning as "grandfathered health plan" in RCW 48.43.005. [2012 c 211 § 15; 2011 c 314 § 1; 2007 c 259 § 19.]

Effective date—2007 c 259 §§ 18-22: See note following RCW 41.05.095.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 48.20.450 Standardization and simplification of terms and coverages—Disclosure requirements. The commissioner shall issue regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of disability insurance which shall be in addition to and in accordance with applicable laws of this state, including RCW 48.20.450 through 48.20.480, which may cover but shall not be limited to:

(1) Terms of renewability;
(2) Initial and subsequent conditions of eligibility;
(3) Nonduplication of coverage provisions;
(4) Coverage of dependents;
(5) Preexisting conditions;
(6) Termination of insurance;
(7) Probationary periods;
(8) Limitations;
(9) Exceptions;
(10) Reductions;
(11) Elimination periods;
(12) Requirements for replacement;
(13) Recurrent conditions; and

(14) The definition of terms including but not limited to the following: Hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and noncancellable. [1985 c 264 § 11; 1975 1st ex.s. c 266 § 16.]

Purpose—1975 1st ex.s. c 266: "The purpose of *sections 14 through 18 of this 1975 amendatory act is to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies to facilitate public understanding and comparison, to eliminate provisions contained in individual disability insurance policies which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of disability coverages." [1975 1st ex.s. c 266 § 15.]

***Reviser's note:** During the course of passage of 1975 1st ex.s. c 266 [Substitute House Bill No. 198], the section numbering was changed, but the internal references were not changed accordingly. Thus the reference "sections 14 through 18 of this 1975 amendatory act" appears to be erroneous. Reference to "sections 15 through 19," codified herein as this section and RCW 48.20.450 through 48.20.480, was apparently intended.

Severability—1975 1st ex.s. c 266: See note following RCW 48.01.010.

RCW 48.20.460 Standardization and simplification—Minimum standards for benefits and coverages. (1) The commissioner shall issue regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy, of disability insurance:

(a) Basic hospital expense coverage;

(b) Basic medical-surgical expense coverage;

(c) Hospital confinement indemnity coverage;

(d) Major medical expense coverage;

(e) Disability income protection coverage;

(f) Accident only coverage;

(g) Specified disease or specified accident coverage;

(h) Medicare supplemental coverage; and

(i) Limited benefit coverage.

(2) Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in items (a) through (f) of subsection (1) of this section.

(3) No policy shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in items (a) through (i) of subsection (1) of this section, unless the commissioner finds such policy will be in the public interest and such policy meets the requirements set forth in RCW 48.18.110.

(4) The commissioner shall prescribe the method of identification of policies based upon coverages provided. [1981 c 339 § 19; 1975 1st ex.s. c 266 § 17.]

Severability—1975 1st ex.s. c 266: See note following RCW 48.01.010.

RCW 48.20.470 Standardization and simplification—Outline of coverage—Format and contents. (1) No policy of individual disability insurance shall be delivered or issued for delivery in this state unless an outline of coverage described in subsection (2) of this section is furnished to the applicant in accord with such rules or regulations as the commissioner shall prescribe.

(2) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1) of this section. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) A statement identifying the applicable category or categories of coverage provided by the policy as prescribed in RCW 48.20.450;

(b) A description of the principal benefits and coverage provided in the policy;

(c) A statement of the exceptions, reductions and limitations contained in the policy;

(d) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and

(e) A statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. [1985 c 264 § 12; 1975 1st ex.s. c 266 § 18.]

Severability—1975 1st ex.s. c 266: See note following RCW 48.01.010.

RCW 48.20.480 Standardization and simplification—Simplified application form—Coverage of loss from preexisting health condition. Notwithstanding the provisions of RCW 48.20.052, if an insurer elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy must cover any loss occurring after twelve months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions. [1975 1st ex.s. c 266 § 19.]

Severability—1975 1st ex.s. c 266: See note following RCW 48.01.010.

RCW 48.20.490 Continuation of coverage by former spouse and dependents. Every policy of disability insurance issued, amended, or renewed after June 12, 1980, for an individual and his/her dependents shall contain provisions to assure that the covered spouse and/or dependents, in the event that any cease to be a qualified family member by reason of termination of marriage or death of the principal insured, shall have the right to continue the policy coverage without

a physical examination, statement of health, or other proof of insurability. [1980 c 10 § 1.]

RCW 48.20.500 Coverage for adopted children. (1) Any disability insurance contract providing hospital and medical expenses and health care services, delivered or issued for delivery in this state, which provides coverage for dependent children, as defined in the contract of the insured, shall cover adoptive children placed with the insured on the same basis as other dependents, as provided in RCW 48.01.180.

(2) If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of placement of a child for adoption and payment of the required premium must be furnished to the insurer. The notification period shall be no less than sixty days from the date of placement. [1986 c 140 § 2.]

Effective date, application—Severability—1986 c 140: See notes following RCW 48.01.180.

RCW 48.20.510 Cancellation of rider. Upon application by an insured, a rider shall be canceled if at least five years after its issuance, no health care services have been received by the insured during that time for the condition specified in the rider, and a physician, selected by the carrier for that purpose, agrees in writing to the full medical recovery of the insured from that condition, such agreement not to be unreasonably withheld. The option of the insured to apply for cancellation shall be disclosed on the face of the rider in clear and conspicuous language.

For purposes of this section, a rider is a legal document that modifies a contract to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. [1987 c 37 § 1.]

RCW 48.20.520 Phenylketonuria. (1) The legislature finds that:

(a) Phenylketonuria is a rare inherited genetic disorder.

(b) Children with phenylketonuria are unable to metabolize an essential amino acid, phenylalanine, which is found in the proteins of most food.

(c) To remain healthy, children with phenylketonuria must maintain a strict diet and ingest a mineral and vitamin-enriched formula.

(d) Children who do not maintain their diets with the formula acquire severe mental and physical difficulties.

(e) Originally, the formulas were listed as prescription drugs but were reclassified as medical foods to increase their availability.

(2) Subject to requirements and exceptions which may be established by rules adopted by the commissioner, any disability insurance contract delivered or issued for delivery or renewed in this state on or after September 1, 1988, that insures for hospital or medical expenses shall provide coverage for the formulas necessary for the treatment of phenylketonuria. [1988 c 173 § 1.]

RCW 48.20.525 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required. Disability insurance companies who through an authorized representative have first approved, by any means, an individual prescription claim as eligible may not reject that claim at some later date. Pharmacists or drug dispensing outlets who obtain preapproval of claims shall keep a written record of the preapproval that consists of identification by name and telephone number of the person who approved the claim. [1993 c 253 § 2.]

Findings—1993 c 253: "The legislature finds that many health care insurance entities are initially approving claims as eligible under an identified program, over the telephone, but denying those same claims when they are submitted for payment. The legislature finds this to be an untenable situation for the providers." [1993 c 253 § 1.]

Effective date—1993 c 253: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately [May 7, 1993]." [1993 c 253 § 6.]

RCW 48.20.530 Nonresident pharmacies. For the purposes of this chapter, a nonresident pharmacy is defined as any pharmacy located outside this state that ships, mails, or delivers, in any manner, except when delivered in person to an enrolled participant or his/her representative, controlled substances, legend drugs, or devices into this state.

After October 1, 1991, an insurer providing coverage of prescription drugs from nonresident pharmacies may only provide coverage from licensed nonresident pharmacies. The insurers shall obtain proof of current licensure in conformity with this section and RCW 18.64.350 through 18.64.400 from the nonresident pharmacy and keep that proof of licensure on file.

The department of health may request from the insurer the proof of current licensure for all nonresident pharmacies through which the insurer is providing coverage for prescription drugs to residents of the state of Washington. This information, which may constitute a full or partial customer list, shall be confidential and exempt from public disclosure, and from the requirements of chapter 42.56 RCW. The board or the department shall not be restricted in the disclosure of the name of a nonresident pharmacy that is or has been licensed under RCW 18.64.360 or 18.64.370 or of the identity of a nonresident pharmacy disciplined under RCW 18.64.350 through 18.64.400. [2005 c 274 § 310; 1991 c 87 § 7.]

Effective date—1991 c 87: See note following RCW 18.64.350.

RCW 48.20.550 Fixed payment insurance—Standard disclosure form. The commissioner shall adopt rules setting forth the content of a standard disclosure form to be provided to all applicants for individual, illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. The standard disclosure shall provide information regarding the level,

type, and amount of benefits provided and the limitations, exclusions, and exceptions under the policy, as well as additional information to enhance consumer understanding. The disclosure shall specifically disclose that the coverage is not comprehensive in nature and will not cover the cost of most hospital and other medical services. Such disclosure form must be filed for approval with the commissioner prior to use. The standard disclosure forms must be provided at the time of solicitation and completion of the application form. All advertising and marketing materials other than the standard disclosure form must be filed with the commissioner at least thirty days prior to use. [2007 c 296 § 2.]

RCW 48.20.555 Fixed payment insurance—Benefit restrictions. Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance policies are not considered to provide coverage for hospital or medical expenses under this chapter, if the benefits provided are a fixed dollar amount that is paid regardless of the amount charged. The benefits may not be related to, or be a percentage of, the amount charged by the provider of service and must be offered as an independent and noncoordinated benefit with any other health plan as defined in *RCW 48.43.005(19). [2007 c 296 § 3.]

***Reviser's note:** RCW 48.43.005 was amended by 2011 c 314 § 3 and by 2011 c 315 § 2, changing subsection (19) to subsection (24). RCW 48.43.005 was subsequently amended by 2012 c 87 § 1, changing subsection (24) to subsection (26). RCW 48.43.005 was subsequently alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (26) to subsection (27), and effective January 1, 2020, changing subsection (26) to subsection (29). RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (29) to subsection (31).

RCW 48.20.580 Mental health services—Definition—Coverage required, when. (1) For the purposes of this section, "mental health services" means:

(a) For health benefit plans issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court-ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and

(b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan that is guaranteed renewable while the

covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) Each disability insurance contract providing coverage for medical and surgical services shall provide coverage for:

(a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the disability insurance contract. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the disability insurance contract imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the disability insurance contract imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the disability insurance contract.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.

(4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable benefit management requirement is applicable to medical and surgical services. [2020 c 228 § 2; 2007 c 8 § 1.]

Effective date—2007 c 8: "This act takes effect January 1, 2008." [2007 c 8 § 8.]

RCW 48.20.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any

statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 115.]