Chapter 48.21 RCW
GROUP AND BLANKET DISABILITY INSURANCE

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RCW 48.21.010 "Group disability insurance" defined—Issuance. (1) Group disability insurance is that form of disability insurance, including stop loss insurance as defined in RCW 48.11.030, provided by a master policy issued to an employer, to a trustee appointed by an employer or employers, or to an association of employers formed for purposes other than obtaining such insurance, covering, with or without their dependents, the employees, or specified categories of the employees, of such employers or their subsidiaries or affiliates,

or issued to a labor union, or to an association of employees formed for purposes other than obtaining such insurance, covering, with or without their dependents, the members, or specified categories of the members, of the labor union or association, or issued pursuant to RCW 48.21.030. Group disability insurance includes the following groups that qualify for group life insurance:

RCW 48.24.020, 48.24.035, 48.24.040, 48.24.045, 48.24.050, 48.24.060, 48.24.070, 48.24.080, 48.24.090, and 48.24.095. A group under RCW 48.24.027 does not qualify as a group for the purposes of this chapter.

(2) Group disability insurance for lines of coverage identified in *RCW 48.43.005(26) (e), (h), (k), and (m) offered to a resident of this state under a group disability insurance policy may be issued to a group other than the groups described in subsection (1) of this section subject to the requirements in this subsection.

(a) A group disability insurance policy offered under this subsection may not be delivered in this state unless the commissioner finds that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premium charged.

(b) A group disability insurance coverage may not be offered under this subsection in this state by an insurer under a policy issued in another state unless the commissioner or the insurance commissioner of another state having requirements substantially similar to those contained in this subsection has made a determination that the requirements have been met. [2016 c 65 s 1; 2011 c 81 s 1; 2010 c 13 s 3; 1992 c 226 s 2; 1949 c 190 s 27; 1947 c 79 s .21.01; Rem. Supp. 1949 s 45.21.01.]

***Reviser's note:** RCW 48.43.005 was 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). Subsequently, RCW 48.43.005 was amended by 2024 c 218 s 1, changing subsection (31) to subsection (33).

Application—1992 c 226: See note following RCW 48.11.030.

RCW 48.21.015 "Group stop loss insurance" defined for the purpose of exemption—Scope of application. Group stop loss insurance is exempt from all sections of this chapter and chapter 48.32A RCW except for RCW 48.21.010 and this section. For the purpose of this exemption, group stop loss is further defined as follows:

(1) The policy must be issued to and insure the employer, the trustee or other sponsor of the plan, or the plan itself, but not the employees, members, or participants;

(2) Payment by the insurer must be made to the employer, the trustee, or other sponsor of the plan or the plan itself, but not to the employees, members, participants, or health care providers;

(3) The policy must contain a provision that establishes an aggregate attaching point or retention that is at the minimum one hundred twenty percent of the expected claims; and

(4) The policy may provide for an individual attaching point or retention that is not less than five percent of the expected claims or one hundred thousand dollars, whichever is less. [2000 c 80 s 8; 1992 c 226 s 3.]

Application—1992 c 226: See note following RCW 48.11.030.

RCW 48.21.020 "Employees," "employer" defined. The term "employees" as used in this chapter shall be deemed to include as employees of a single employer, the compensated officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used in this chapter shall be deemed to include any municipal corporation or governmental unit, agency or department thereof as well as private individuals, firms, corporations and other persons. [1947 c 79 s .21.02; Rem. Supp. 1947 s 45.21.02.]

RCW 48.21.030 Health care groups. A policy of group disability insurance may be issued to a corporation, as policyholder, existing primarily for the purpose of assisting individuals who are its subscribers in securing medical, hospital, dental, and other health care services for themselves and their dependents, covering all and not less than five hundred such subscribers and dependents, with respect only to medical, hospital, dental, and other health care services. [1947 c 79 s .21.03; Rem. Supp. 1947 s 45.21.03.]

RCW 48.21.040 "Blanket disability insurance" defined. (1) Any policy or contract of disability insurance which conforms with the description and complies with the requirements contained in one of the following six paragraphs shall be deemed a blanket disability insurance policy:

(a) A policy issued to any common carrier of passengers, which carrier shall be deemed the policyholder, covering a group defined as all persons who may become such passengers, and whereby such passengers shall be insured against loss or damage resulting from death or bodily injury either while, or as a result of, being such passengers.

(b) A policy issued in the name of any volunteer fire department, first aid or ambulance squad or volunteer police organization, which shall be deemed the policyholder, and covering all the members of any such organization against loss from accidents resulting from hazards incidental to duties in connection with such organizations.

(c) A policy issued in the name of any established organization whether incorporated or not, having community recognition and operated for the welfare of the community and its members and not for profit, which shall be deemed the policyholder, and covering all volunteer workers who serve without pecuniary compensation and the members of

the organization, against loss from accidents occurring while engaged in the actual performance of duties on behalf of such organization or in the activities thereof.

(d) A policy issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employees against death or bodily injury resulting while, or from, being exposed to such exceptional hazards.

(e) A policy covering students or employees issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder.

(f) A policy or contract issued to any other substantially similar group, which, in the commissioner's discretion, may be subject to the insurance of a blanket disability policy or contract.

(2) Nothing contained in this section shall be deemed to affect the liability of policyholders for the death of, or injury to, any such members of such group.

(3) Individual applications shall not be required from individuals covered under a blanket disability insurance contract. [1959 c 225 s 7; 1947 c 79 s .21.04; Rem. Supp. 1947 s 45.21.04.]

RCW 48.21.045 Health plan benefits for small employers—Coverage—Exemption from statutory requirements—Premium rates—Requirements for providing coverage for small employers—Definitions. (1)(a) An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. An insurer offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

(2) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(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; and

(iv) 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. Employees 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 (3).

(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. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may, after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(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 enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

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

(g) On the census date, as defined in RCW 48.21.047, rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, and differences in census date between new and renewal groups, with the exception of discounts for health improvement programs.

(h) 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. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage, including the small group participants in the health insurance

partnership established in **RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(j) For health benefit plans purchased through the health insurance partnership established in **chapter 70.47A RCW:

(i) Any surcharge established pursuant to **RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(k) If the rate developed under this section varies the adjusted community rate for the factors listed in (a) of this subsection, the date for determining those factors must be no more than ninety days prior to the effective date of the health benefit plan.

(4) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection and subsection (3)(g) of this section, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under **RCW 70.47A.110 shall apply only to the employers and

employees who purchase health benefit plans through the health insurance partnership.

(6) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

(7) As used in this section, "health benefit plan," "small employer," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005. [2010 c 292 s 7; 2009 c 131 s 1; 2008 c 143 s 6; 2007 c 260 s 7; 2004 c 244 s 1; 1995 c 265 s 14; 1990 c 187 s 2.]

Reviser's note: *(1) RCW 48.43.015 was repealed by 2019 c 33 s 7.

**(2) Chapter 70.47A RCW was repealed in its entirety by 2017 3rd sp.s. c 25 s 9.

Application—2010 c 292: See note following RCW 48.43.005.

Application—2004 c 244: "Sections 1 through 15 of this act apply to all small group health benefit plans issued or renewed on or after June 10, 2004." [2004 c 244 s 17.]

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

Finding—Intent—1990 c 187: "The legislature finds that the rising cost of comprehensive group health coverage is exceeding the affordability of many small businesses and their employees. The legislature further finds that certain public policies have an adverse impact on the cost of such coverage. It is therefore the intent of the legislature to reduce costs by authorizing the development of basic hospital and medical coverage for small groups." [1990 c 187 s 1.]

Severability—1990 c 187: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1990 c 187 s 6.]

RCW 48.21.047 Requirements for plans offered to small employers—Definitions. (1) An insurer may not offer any health benefit plan to any small employer without complying with RCW 48.21.045(3).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.21.045(3).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

(4) For purposes of this section, "census date" has the same meaning as defined in RCW 48.44.010. [2010 c 292 s 8; 2005 c 223 s 11; 1995 c 265 s 22.]

Application—2010 c 292: See note following RCW 48.43.005.

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

RCW 48.21.050 Standard provisions required. Every policy of group or blanket disability insurance shall contain in substance the provisions as set forth in RCW 48.21.060 to 48.21.090, inclusive, or provisions which in the opinion of the commissioner are more favorable to the individuals insured, or at least as favorable to such individuals and more favorable to the policyholder. No such policy of group or blanket disability insurance shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the individuals insured than would be permitted by the standard provisions required for individual disability insurance policies. [1947 c 79 s .21.05; Rem. Supp. 1947 s 45.21.05.]

RCW 48.21.060 The contract—Representations. There shall be a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued; that all statements made by the policyholder or by the individuals insured shall in the absence of fraud be deemed representations and not warranties, and that no statement made by any individual insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such individual or to his or her beneficiary, if any. [2009 c 549 s 7102; 1947 c 79 s .21.06; Rem. Supp. 1947 s 45.21.06.]

RCW 48.21.070 Payment of premiums. There shall be a provision that all premiums due under the policy shall be remitted by the employer or employers of the persons insured, by the policyholder, or by some other designated person acting on behalf of the association or group insured, to the insurer on or before the due date thereof with such period of grace as may be specified therein. [1947 c 79 s . 21.07; Rem. Supp. 1947 s 45.21.07.]

RCW 48.21.075 Payment of premiums by employee in event of suspension of compensation due to labor dispute. Any employee whose compensation includes group disability or blanket disability insurance providing health care services, the premiums for which are paid in full or in part by an employer including the state of Washington, its political subdivisions, or municipal corporations, or paid by payroll deduction, may pay the premiums as they become due directly to the policyholder whenever the employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute, for a period not exceeding six months and at the rate and coverages as the policy provides. During that period of time the policy may not be altered or changed. Nothing in this section shall be deemed to impair the right of the insurer to make normal decreases or increases of the premium rate upon expiration and renewal

of the policy, in accordance with the provisions of the policy. Thereafter, if such insurance coverage is no longer available, then the employee shall be given the opportunity to purchase an individual policy at a rate consistent with rates filed by the insurer with the commissioner. When the employee's compensation is so suspended or terminated, the employee shall be notified immediately by the policyholder in writing, by mail addressed to the address last on record with the policyholder, that the employee may pay the premiums to the policyholder as they become due as provided in this section.

Payment of the premiums must be made when due or the insurance coverage may be terminated by the insurer.

The provisions of any insurance policy contrary to provisions of this section are void and unenforceable after May 29, 1975. [1975 1st ex.s. c 117 s 1.]

Severability—1975 1st ex.s. c 117: "If any provision of this 1975 act, or its application to any person or circumstance is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected." [1975 1st ex.s. c 117 s 4.]

RCW 48.21.080 Certificates of coverage. In group disability insurance policies there shall be a provision that the insurer shall issue to the employer, the policyholder, or other person or association in whose name such policy is issued, for delivery to each insured employee or member, a certificate setting forth in summary form a statement of the essential features of the insurance coverage, and to whom the benefits thereunder are payable described by name, relationship, or reference to the insurance records of the policyholder or insurer. If family members are insured, only one certificate need be issued for each family. This section shall not apply to blanket disability insurance policies. [1961 c 194 s 6; 1947 c 79 s .21.08; Rem. Supp. 1947 s 45.21.08.]

RCW 48.21.090 Age limitations. There shall be a provision specifying the ages, if any there be, to which the insurance provided therein shall be limited; and the ages, if any there be, for which additional restrictions are placed on benefits, and the additional restrictions placed on the benefits at such ages. [1947 c 79 s . 21.09; Rem. Supp. 1947 s 45.21.09.]

RCW 48.21.100 Examination and autopsy. There may be a provision that the insurer shall have the right and opportunity to examine the person of the insured employee, member or dependent when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law. [1947 c 79 s .21.10; Rem. Supp. 1947 s 45.21.10.]

RCW 48.21.110 Payment of benefits. The benefits payable under any policy or contract of group or blanket disability insurance shall be payable to the employee or other insured member of the group or to

the beneficiary designated by him or her, other than the policyholder, employer or the association or any officer thereof as such, subject to provisions of the policy in the event there is no designated beneficiary as to all or any part of any sum payable at the death of the individual insured.

The policy may provide that any hospital, medical, or surgical benefits thereunder may be made payable jointly to the insured employee or member and the person furnishing such hospital, medical, or surgical services. [2009 c 549 s 7103; 1955 c 303 s 17; 1947 c 79 s .21.11; Rem. Supp. 1947 s 45.21.11.]

RCW 48.21.120 Readjustment of premiums—Dividends. Any contract of group disability insurance may provide for the readjustment of the rate of premium based on the experience thereunder at the end of the first year or of any subsequent year of insurance thereunder, and such readjustment may be made retroactive only for such policy year. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies heretofore or hereafter issued, and any dividend paid under such policies may be used to reduce the employer's share of the cost of the coverage, except that if the aggregate refunds or dividends under such group policy and any other group policy or contract issued to the policyholder exceed the aggregate contributions of the employer toward the cost of the coverages, such excess shall be applied by the policyholder for the sole benefit of insured employees. [1947 c 79 s .21.12; Rem. Supp. 1947 s 45.21.12.]

RCW 48.21.125 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 s 3.]

Finding—Application—2004 c 112: See notes following RCW 48.20.385.

RCW 48.21.130 Podiatric medicine and surgery. Notwithstanding any provision of any group disability insurance contract or blanket 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 s 2.]

Application—1963 c 87: Nonapplicability to prior contracts and certain renewals, see note following RCW 48.20.390.

RCW 48.21.140 Optometry. Notwithstanding any provision of any group disability insurance contract or blanket 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 s 3.]

Construction—1965 c 149: Nonapplicability to prior contracts and certain renewals, see note following RCW 48.20.410.

RCW 48.21.141 Registered nurses or advanced registered nurses. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health 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 s 730; 1973 1st ex.s. c 188 s 4.]

***Reviser's note:** The term "advanced registered nursing practice" was changed to "advanced practice registered nursing" by 2024 c 239 s 3, effective June 30, 2027.

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 48.21.142 Chiropractic. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health 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 s 2.]

RCW 48.21.143 Diabetes coverage—Definitions. 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 group disability insurance contracts and blanket disability insurance contracts providing health care services, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For group disability insurance contracts and blanket disability insurance contracts that include coverage for 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 group disability insurance contracts and blanket 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. [2020 c 346 s 8; 2020 c 245 s 4; 2004 c 244 s 10; 1997 c 276 s 3.]

Reviser's note: This section was amended by 2020 c 245 s 4 and by 2020 c 346 s 8, 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.

Application—2004 c 244: See note following RCW 48.21.045.

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

RCW 48.21.144 Psychological services. Notwithstanding any provision of any group disability insurance contract or blanket 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 s 2.]

Application—1971 ex.s. c 197: See note following RCW 48.20.414.

RCW 48.21.146 Dentistry. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract as provided for in this chapter, benefits shall not be denied thereunder for any health 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 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 s 2.]

RCW 48.21.147 Dental services that are not subject to contract or provider agreement. (1) Notwithstanding any other provisions of law, no group disability insurance contract or blanket disability insurance contract of any disability insurer as provided for 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 group plan or 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, group plan, 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 s 2.]

RCW 48.21.148 Denturist services. Notwithstanding any provision of any group disability insurance contract or blanket 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 s 22 (Initiative Measure No. 607, approved November 8, 1994).]

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

RCW 48.21.150 Dependent child coverage—Continuation for incapacity. Any group disability insurance contract or blanket 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 of an employee or other member of the covered group 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 employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member 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 s 31; 1977 ex.s. c 80 s 32; 1969 ex.s. c 128 s 4.]

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

RCW 48.21.155 Dependent child coverage—From moment of birth—Congenital anomalies—Notification of birth. (1) Any group disability insurance contract except blanket disability insurance contract, providing hospital and medical expenses and health care services, renewed, delivered or issued for delivery in this state more than one hundred twenty days after February 16, 1974, which provides coverage for the dependent children of persons in the insured group, shall provide coverage for newborn infant children of persons in the insured group 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 s 20; 1974 ex.s. c 139 s 2.]

RCW 48.21.157 Option to cover dependents under age twenty-six. Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any dependent under the age of twenty-six. [2011 c 314 s 17; 2007 c 259 s 20.]

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

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

RCW 48.21.160 Chemical dependency benefits—Legislative declaration. The legislature recognizes that chemical dependency is a disease and, as such, warrants the same attention from the health care industry as other similarly serious diseases warrant; the legislature further recognizes that health insurance contracts and contracts for health care services include inconsistent provisions providing benefits for the treatment of chemical dependency. In order to assist the many citizens of this state who suffer from the disease of chemical dependency, and who are presently effectively precluded from obtaining adequate coverage for medical assistance under the terms of their health insurance contract or health care service contract, the legislature hereby declares that provisions providing benefits for the treatment of chemical dependency shall be included in new contracts and that this section, RCW 48.21.180, 48.21.190, 48.44.240, 48.46.350, and RCW 48.21.195, 48.44.245, and 48.46.355 are necessary for the protection of the public health and safety. Nothing in this section, RCW 48.21.180, 48.21.190, 48.44.240, 48.46.350, and RCW 48.21.195, 48.44.245, and 48.46.355 shall be construed to relieve any person of any civil or criminal liability for any act or omission that is the result of a chemical dependency or to grant any person with a chemical dependency any special right, privilege, or status under the law against discrimination, chapter 49.60 RCW. [1987 c 458 s 13; 1974 ex.s. c 119 s 1.]

Effective date—1987 c 458 ss 13-20: "Sections 13 through 20 of this act shall take effect on January 1, 1988." [1987 c 458 s 24.]

Severability—1987 c 458: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1987 c 458 s 25.]

RCW 48.21.180 Chemical dependency benefits—Contracts issued or renewed after January 1, 1988. Each group disability insurance contract which is delivered or issued for delivery or renewed, on or after January 1, 1988, and which insures for hospital or medical care must contain provisions providing benefits for the treatment of chemical dependency rendered to the insured by a provider which is an "approved substance use disorder treatment program" under *RCW 70.96A.020(2). [2018 c 201 s 8011; 2003 c 248 s 9; 1990 1st ex.s. c 3 s 7; 1987 c 458 s 14; 1974 ex.s. c 119 s 3.]

***Reviser's note:** RCW 70.96A.020 was repealed by 2016 sp.s. c 29 s 301.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Severability—1987 c 458: See notes following RCW 48.21.160.

RCW 48.21.190 Chemical dependency benefits—RCW 48.21.160 through 48.21.190, 48.44.240 inapplicable, when. RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to the renewal of a contract in force prior to the pertinent date provided for such contract under RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended where there exists a right of renewal on the part of the insured or subscriber without any change in any provision of the contract: PROVIDED FURTHER, That RCW 48.21.160 through 48.21.190 and 48.44.240 as now or hereafter amended shall not apply to contracts which provide only accident coverage, nor to any contract written as supplemental coverage to any federal or state programs of health care including, but not limited to, Title XVIII health insurance for the aged (commonly referred to as Medicare, Parts A and B), and amendments thereto. [1975 1st ex.s. c 266 s 10; 1974 ex.s. c 119 s 5.]

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

RCW 48.21.195 "Chemical dependency" defined. For the purposes of RCW 48.21.160 and 48.21.180 "chemical dependency" means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. [1987 c 458 s 15.]

Effective date—Severability—1987 c 458: See notes following RCW 48.21.160.

RCW 48.21.197 Chemical dependency benefits—Rules. By September 1, 1987, the insurance commissioner shall adopt rules governing benefits for treatment of chemical dependency under medical plans issued under chapters 48.21, 48.44, and 48.46 RCW. These rules shall recognize that many persons are dependent on both alcohol and drugs; they shall prohibit the stacking of benefits and shall require that benefits for chemical dependency be equivalent to benefits previously required for alcoholism. [1987 c 458 s 21.]

Severability—1987 c 458: See note following RCW 48.21.160.

RCW 48.21.200 Individual or group disability, health care service contract, health maintenance agreement—Reduction of benefits on basis of other existing coverages. (1) No individual or group disability insurance policy, health care service contract, or health maintenance agreement providing hospital, medical or surgical expense benefits and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to one hundred percent of total allowable expenses.

(2) The commissioner shall by rule establish guidelines for the application of this section, including:

(a) The procedures by which persons covered under such policies, contracts, and agreements are to be made aware of the existence of such a provision;

(b) The benefits which may be subject to such a provision;

(c) The effect of such a provision on the benefits provided;

(d) Establishment of the order of benefit determination;

(e) Exceptions necessary to preserve policy, contract, or agreement requirements for use of particular health care facilities or providers; and

(f) Reasonable claim administration procedures to expedite claim payments and prevent duplication of payments or benefits under such a provision. [2007 c 80 s 3; 1993 c 492 s 282. Prior: 1983 c 202 s 16; 1983 c 106 s 24; 1975 1st ex.s. c 266 s 20.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

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

RCW 48.21.220 Home health care, hospice care, optional coverage required—Standards, limitations, restrictions—Rules—Medicare supplemental contracts excluded. (1) Every insurer entering into or renewing group or blanket disability insurance policies governed by this chapter shall offer optional coverage for home health care and hospice care for persons who are homebound and would otherwise require hospitalization. Such optional coverage need only be offered in conjunction with a policy that provides payment for hospitalization as a part of health care coverage. Persons seeking such services for

palliative care in conjunction with treatment or management of serious or life-threatening illness need not be homebound in order to be eligible for coverage under this section.

(2) Home health care and hospice care coverage offered under subsection (1) of this section shall conform to the following standards, limitations, and restrictions in addition to those set forth in chapter 70.126 RCW:

(a) The coverage may include reasonable deductibles, coinsurance provisions, and internal maximums;

(b) The coverage should be structured to create incentives for the use of home health care and hospice care as an alternative to hospitalization;

(c) The coverage may contain provisions for utilization review and quality assurance;

(d) The coverage may require that home health agencies and hospices have written treatment plans approved by a physician licensed under chapter 18.57 or 18.71 RCW, and may require such treatment plans to be reviewed at designated intervals;

(e) The coverage shall provide benefits for, and restrict benefits to, services rendered by home health and hospice agencies licensed by the department of social and health services;

(f) Hospice care coverage shall provide benefits for terminally ill patients for an initial period of care of not less than six months and may provide benefits for an additional six months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the attending physician;

(g) Home health care coverage shall provide benefits for a minimum of one hundred thirty health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit;

(h) The coverage may be structured so that services or supplies included in the primary contract are not duplicated in the optional home health and hospice coverage.

(3) The insurance commissioner shall adopt any rules necessary to implement this section.

(4) The requirements of this section shall not apply to contracts or policies governed by chapter 48.66 RCW.

(5) An insurer, as a condition of reimbursement, may require compliance with home health and hospice certification regulations established by the United States department of health and human services. [2015 c 22 s 1; 1988 c 245 s 31; 1984 c 22 s 1; 1983 c 249 s 1.]

Application—2015 c 22: "This act applies to plans issued or renewed after December 31, 2016." [2015 c 22 s 4.]

Effective date—1984 c 22: "This act shall take effect July 1, 1984." [1984 c 22 s 8.]

Effective date—1983 c 249: See note following RCW 70.126.001.

Home health care, hospice care, rules: Chapter 70.126 RCW.

RCW 48.21.223 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 s 20; 2011 c 159 s 4.]

***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). Subsequently, RCW 48.43.005 was amended by 2024 c 218 s 1, changing subsections (27) and (28) to subsections (29) and (30).

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

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

RCW 48.21.225 Mammograms—Insurance coverage. Each group 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 s 4; 1994 sp.s. c 9 s 731; 1989 c 338 s 2.]

Reviser's note: *(1) The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

**(2) 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 48.21.227 Prostate cancer screening. (1) Each group 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 s 3.]

***Reviser's note:** The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

RCW 48.21.230 Reconstructive breast surgery. (1) Each group disability insurance contract issued or renewed after July 24, 1983, which insures for hospital or medical care shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.

(2) Each group disability insurance contract issued or renewed after January 1, 1986, which insures for hospital or medical care 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 s 6; 1983 c 113 s 2.]

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

RCW 48.21.235 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 s 2.]

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

RCW 48.21.241 Mental health services—Group health plans—Definition—Coverage required, when. (1) For the purposes of this section, "mental health services" means:

(a) For health benefit plans that provide coverage for medical and surgical services 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 health benefit plans that provide coverage for medical and surgical services 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) All group disability insurance contracts and blanket disability insurance contracts providing health benefit plans that provide 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 health benefit plan. 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 health benefit plan 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 health benefit plan 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 health benefit plan.

(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 requirement is applicable to medical and surgical services. [2020 c 228 s 3; 2007 c 8 s 2; 2006 c 74 s 1; 2005 c 6 s 3.]

Effective date—2007 c 8: See note following RCW 48.20.580.

Effective date—2006 c 74: "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 [March 15, 2006]." [2006 c 74 s 4.]

Findings—Intent—Severability—2005 c 6: See notes following RCW 41.05.600.

RCW 48.21.242 Mental health treatment—Waiver of preauthorization for persons involuntarily committed. An insurer providing group disability insurance coverage for health care in this state shall waive a preauthorization requirement from the insurer before an insured or the insured's covered dependents receive mental health care and treatment rendered by a state hospital if the insured or any of the insured's covered dependents are involuntarily committed to a state hospital as defined in RCW 72.23.010. [1993 c 272 s 3.]

Savings—Severability—1993 c 272: See notes following RCW 43.20B.347.

RCW 48.21.244 Benefits for prenatal diagnosis of congenital disorders—Contracts entered into or renewed on or after January 1, 1990. On or after January 1, 1990, every group disability contract entered into or renewed that covers hospital, medical, or surgical expenses on a group basis, and which provides benefits for pregnancy, childbirth, or related medical conditions to enrollees of such groups, shall offer benefits for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy to such enrollees when those services are determined to be medically necessary by the disability contractor in accord with standards set in rule by the board of health. Every group disability contractor shall communicate the availability of such coverage to all group disability contract holders and to all groups with whom they are negotiating. [1988 c 276 s 6.]

Prenatal testing—Limitation on changes to coverage: RCW 48.42.090.

RCW 48.21.250 Continuation option to be offered. Every insurer that issues policies providing group coverage for hospital or medical expense shall offer the policyholder an option to include a policy provision granting a person who becomes ineligible for coverage under the group policy, the right to continue the group benefits for a period of time and at a rate agreed upon. The policy provision shall provide that when such coverage terminates, the covered person may convert to a policy as provided in RCW 48.21.260. [1984 c 190 s 2.]

Legislative intent—1984 c 190: "The legislature recognizes that when people covered by a group health insurance policy lose their group insurance benefits because they are no longer eligible, they need time to obtain a suitable form of replacement coverage or time to complete a reasonable course of medical treatment for a health condition that existed when the group benefits ended.

Spouses and dependents can lose their group insurance and may not have any other health insurance when one spouse covered under a group policy dies, obtains a divorce, or becomes unemployed. Often the cost

of an individual policy prevents these persons from obtaining any other health insurance.

The intent of this act is to require insurers, health care service contractors, and health maintenance organizations to:

(1) Offer to the contract holder the option to continue health and medical benefits for employees, members, spouses, or dependents whose eligibility for coverage under a group policy, contract, or agreement is terminated; and

(2) Provide a conversion policy, contract, or agreement to employees, members, spouses, or dependents whose eligibility for coverage under a group policy, contract, or agreement is terminated." [1984 c 190 s 1.]

Application—1984 c 190 ss 2, 5, and 8: "Sections 2, 5, and 8 of this act shall apply to any policy, contract, or agreement issued, renewed, or amended on or after January 1, 1985." [1984 c 190 s 12.]

Severability—1984 c 190: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1984 c 190 s 13.]

RCW 48.21.260 Conversion policy to be offered—Exceptions, conditions. (1) Except as otherwise provided by this section, any group disability insurance policy that provides benefits for hospital or medical expenses must contain a provision granting a person covered by the group policy the right to obtain a conversion policy from the insurer upon termination of the person's eligibility for coverage under the group policy.

(2) An insurer need not offer a conversion policy to:

(a) A person whose coverage under the group policy ended when the person's employment or membership was terminated for misconduct: PROVIDED, That when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct;

(b) A person who is eligible for federal medicare coverage; or

(c) A person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

(3) To obtain the conversion policy, a person must submit a written application and the first premium payment for the conversion policy not later than thirty-one days after the date the person's group coverage terminates or thirty-one days after the date the person received notice of termination of coverage, whichever is later. The conversion policy shall become effective, without lapse of coverage, immediately following termination of coverage under the group policy.

(4) If an insurer or group policyholder does not renew, cancels, or otherwise terminates the group policy, the insurer must offer a conversion policy to any person who was covered under the terminated policy unless the person is eligible to obtain group hospital or medical expense coverage within thirty-one days after such nonrenewal,

cancellation, or termination of the group policy or thirty-one days after the date the person received notice of termination of coverage, whichever is later.

(5) The insurer shall determine the premium for the conversion policy in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the policy and the type and amount of benefits provided. [2010 c 110 s 1; 1984 c 190 s 3.]

Application—2010 c 110: "This act applies to any group disability insurance policy, group health care service contract, and group health maintenance agreement issued, entered into, or renewed on or after January 1, 2011." [2010 c 110 s 4.]

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

RCW 48.21.270 Conversion policy—Restrictions and requirements—Rules. (1) An insurer shall not require proof of insurability as a condition for issuance of the conversion policy.

(2) A conversion policy may not contain an exclusion for preexisting conditions for any applicant.

(3) An insurer must offer at least three policy benefit plans that comply with the following:

(a) A major medical plan with a five thousand dollar deductible per person;

(b) A comprehensive medical plan with a five hundred dollar deductible per person; and

(c) A basic medical plan with a one thousand dollar deductible per person.

(4) The insurance commissioner may revise the deductible amounts in subsection (3) of this section from time to time to reflect changing health care costs.

(5) The insurance commissioner shall adopt rules to establish minimum benefit standards for conversion policies.

(6) The commissioner shall adopt rules to establish specific standards for conversion policy provisions. These rules may include but are not limited to:

(a) Terms of renewability;

(b) Nonduplication of coverage;

(c) Benefit limitations, exceptions, and reductions; and

(d) Definitions of terms. [2019 c 33 s 4; 2011 c 314 s 2; 1984 c 190 s 4.]

Effective date—2019 c 33: See note following RCW 48.43.005.

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

RCW 48.21.280 Coverage for adopted children. (1) Any group disability insurance contract, except a blanket 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 s 3.]

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

RCW 48.21.290 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 s 2.]

RCW 48.21.300 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 group 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 s 2.]

RCW 48.21.310 Neurodevelopmental therapies—Employer-sponsored group contracts. (1) Each employer-sponsored group policy for comprehensive health insurance which is entered into, or renewed, on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individuals age six and under.

(2) Benefits provided under this section shall cover the services of those authorized to deliver occupational therapy, speech therapy, and physical therapy. Benefits shall be payable only where the

services have been delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where covered services have been rendered by such licensee. Nothing in this section shall prohibit an insurer from negotiating rates with qualified providers.

(3) Benefits provided under this section shall be for medically necessary services as determined by the insurer. Benefits shall be payable for services for the maintenance of an insured in cases where significant deterioration in the patient's condition would result without the service. Benefits shall be payable to restore and improve function.

(4) It is the intent of this section that employers purchasing comprehensive health insurance, including the benefits required by this section, together with the insurer, retain authority to design and employ utilization and cost controls. Therefore, benefits delivered under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the employer purchasing insurance and the insurer. Benefits provided under this section may be subject to standard waiting periods for preexisting conditions, and may be subject to the submission of written treatment plans.

(5) In recognition of the intent expressed in subsection (4) of this section, benefits provided under this section may be subject to contractual provisions establishing annual and/or lifetime benefit limits. Such limits may define the total dollar benefits available or may limit the number of services delivered as agreed by the employer purchasing insurance and the insurer. [1989 c 345 s 2.]

RCW 48.21.320 Temporomandibular joint disorders—Insurance coverage. (1) Except as provided in this section, a group disability policy entered into or renewed after December 31, 1989, shall offer optional coverage for the treatment of temporomandibular joint disorders.

(a) Insurers offering medical coverage only may limit benefits in such coverages to medical services related to treatment of temporomandibular joint disorders. Insurers offering dental coverage only may limit benefits in such coverage to dental services related to treatment of temporomandibular joint disorders. No insurer offering medical coverage only may define all temporomandibular joint disorders as purely dental in nature, and no insurer offering dental coverage only may define all temporomandibular joint disorders as purely medical in nature.

(b) Insurers offering optional temporomandibular joint disorder coverage as provided in this section may, but are not required to, offer lesser or no temporomandibular joint disorder coverage as part of their basic group disability contract.

(c) Benefits and coverage offered under this section may be subject to negotiation to promote broad flexibility in potential benefit coverage. This flexibility shall apply to services to be reimbursed, determination of treatments to be considered medically necessary, systems through which services are to be provided, including referral systems and use of other providers, and related issues.

(2) Unless otherwise directed by law, the insurance commissioner shall adopt rules, to be implemented on January 1, 1993, establishing

minimum benefits, terms, definitions, conditions, limitations, and provisions for the use of reasonable deductibles and copayments.

(3) An insurer need not make the offer of coverage required by this section to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefit statutes under Title 48 RCW that does not provide coverage for temporomandibular joint disorders. [1989 c 331 s 2.]

Legislative finding—1989 c 331: "The legislature finds that:

(1) Temporomandibular joint disorders are conditions for which treatment often is not covered in medical and dental group insurance contracts;

(2) Individuals with temporomandibular joint disorders experience substantial pain and financial hardship;

(3) Public awareness is needed concerning temporomandibular joint disorders and would be promoted by a mandated offering of temporomandibular joint disorders coverage to group purchasers; and

(4) A mandated offering of temporomandibular joint disorders coverage shall not prescribe minimum initial benefits so that the insurers and the purchasers are allowed broad flexibility in benefit design and application." [1989 c 331 s 1.]

Effective date—1989 c 331: "This act shall take effect January 1, 1990, but the insurance commissioner may immediately take such steps as are necessary to ensure that this act is fully implemented on its effective date." [1989 c 331 s 6.]

RCW 48.21.325 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required. Group 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 s 3.]

Findings—Effective date—1993 c 253: See notes following RCW 48.20.525.

RCW 48.21.330 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 may request from the insurer the proof of current licensure for all nonresident pharmacies through which the insurer is

providing coverage for prescription drugs for 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 s 311; 1991 c 87 s 8.]

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

RCW 48.21.370 Fixed payment insurance—Standard disclosure form. The commissioner shall adopt rules setting forth the content of a standard disclosure form to be delivered to all applicants for group 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 form must be provided to the master policyholders at the time of solicitation and completion of the application and to all enrollees at the time of enrollment. 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 s 4.]

RCW 48.21.375 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 or care 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 s 5.]

***Reviser's note:** RCW 48.43.005 was amended by 2011 c 314 s 3 and by 2011 c 315 s 2, changing subsection (19) to subsection (24). RCW 48.43.005 was subsequently amended by 2012 c 87 s 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). Subsequently, RCW 48.43.005 was amended by 2024 c 218 s 1, changing subsection (31) to subsection (33).

RCW 48.21.380 Noninsurance benefits. (1) A disability insurer may include the following noninsurance benefits as part of a policy or certificate of group disability insurance, with the prior approval of the commissioner and where such benefits bear a reasonable relationship to the disability insurance with which they are intended to be offered:

(a) Will preparation services;

(b) Financial planning and estate planning services;

(c) Probate and estate settlement services;

(d) Grief counseling;

(e) Funeral planning and funeral services, but it must be disclosed that this noninsurance benefit does not constitute an insurance funded prearrangement contract, pursuant to RCW 18.39.255; and

(f) Such other services as the commissioner may identify by rule.

(2) The commissioner may adopt rules to regulate the disclosure of noninsurance benefits permitted under this section, including but not limited to guidelines regarding the coverage provided under the policy or certificate of insurance.

(3) Those providing the services listed in subsection (1) of this section must be appropriately licensed.

(4) This section does not require the commissioner to approve any particular proposed noninsurance benefit. The commissioner may disapprove any proposed noninsurance benefit that the commissioner determines may tend to promote or facilitate the violation of any other section of this title.

(5) This section does not expand, limit, or otherwise affect the authority and ethical obligations of those who are authorized by the state supreme court to practice law in this state. This section does not limit the prohibition against the unauthorized practice of law under chapter 2.48 RCW.

(6) This section does not affect the application of chapter 21.20 RCW.

(7) This section does not affect wellness programs as described in RCW 48.30.140(6). [2017 c 32 s 2; 2016 c 143 s 2.]

RCW 48.21.900 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 s 116.]