

**WAC 284-170-360 Enrollee's access to providers.** (1) Each issuer must allow an enrollee to choose a primary care provider who is accepting new patients from a list of participating providers.

(a) Enrollees also must be permitted to change primary care providers at any time with the change becoming effective not later than the beginning of the month following the enrollee's request for the change.

(b) The issuer must ensure at all times that there are a sufficient number of primary care providers in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrollees have the ability to change primary care providers.

(2) Each issuer must allow an enrolled child direct access to a pediatrician from a list of participating pediatricians within their network who are accepting new patients.

(a) Enrollees must be permitted to change pediatricians at any time, with the change becoming effective not later than the beginning of the month following the enrollee's request for the change.

(b) Each issuer must ensure at all times that there are a sufficient number of pediatricians in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrolled children have the ability to change pediatricians.

(3) Each issuer must have a process whereby an enrollee with a complex or serious medical condition or mental health or substance use disorder, including behavioral health condition, may receive a standing referral to a participating specialist for an extended period of time. The standing referral must be consistent with the enrollee's medical or mental health needs and plan benefits. For example, a one-month standing referral would not satisfy this requirement when the expected course of treatment was indefinite. However, a referral does not preclude issuer performance of utilization review functions.

(4) Each issuer must provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection prevents issuers from restricting enrollees to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes such as prior authorization for services. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(5) Each issuer must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice. The issuer may not impose any charge or cost upon the enrollee for such second opinion other than the charge or cost imposed for the same service in otherwise similar circumstances.

[Statutory Authority: RCW 48.02.060 and 48.43.732(5). WSR 26-01-200 (Matter R 2025-10), s 284-170-360, filed 12/23/25, effective 1/23/26. Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-360, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9983, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515,

48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080,  
48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), §  
284-43-251, filed 12/14/15, effective 1/14/16. Statutory Authority:  
RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050,  
48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520,  
48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02),  
§ 284-43-251, filed 1/9/01, effective 7/1/01.]