(b) the name and address of the decedent's employer at the time the injury occurred;

(6) **Asbestos Certification Appeals.** In appeals arising under chapter 49.26 RCW concerning the denial, suspension or revocation of certificates involving asbestos projects, the notice of appeal shall also contain:

(a) A statement identifying the certification decision appealed from;

(b) The reason why the appealing party considers such certification decision to be incorrect.

(7) **WISHA Appeals.** In appeals arising under the Washington Industrial Safety and Health Act (chapter 49.17 RCW), the appeal shall also contain:

(a) A statement identifying the citation, penalty assessment, or notice of abatement date appealed from;

(b) The name and address of the representative of any labor union representing any employee who was or who may be affected by the alleged safety violation(s);

(c) A statement certifying compliance with WAC 263-12-059;

(8) **Other Safety Appeals.** In appeals arising under chapter 49.22 RCW concerning alleged violations of safety procedures in late night retail establishments, chapter 70.74 RCW concerning alleged violations of the Washington State Explosives Act, or chapter 88.04 RCW concerning alleged violations of the Charter Boat Safety Act, the notice of appeal shall also contain:

(a) A statement identifying the citation, penalty assessment, or notice of abatement date appealed from;

(b) The name and address of the representative of any labor union representing any employee who was or who may be affected by the alleged safety violation or violations;

(c) A statement certifying compliance with WAC 263-12-059.

[Statutory Authority: RCW 51.52.020. 01-09-031, § 263-12-050, filed 4/11/01, effective 5/12/01; 00-23-021, § 263-12-050, filed 11/7/00, effective 12/8/00; 91-13-038, § 263-12-050, filed 6/14/91, effective 7/15/91. Statutory Authority: RCW 51.52.104, 51.52.020 and chapters 51.48 and 42.17 RCW. 86-03-021 (Order 20), § 263-12-050, filed 1/10/86. Statutory Authority: RCW 51.52.020. 82-03-031 (Order 11), § 263-12-050, filed 1/18/82; Order 7, § 263-12-050, filed 4/4/75; Order 4, § 263-12-050, filed 6/9/72; Rule 5.1, filed 6/12/63; Rules 3.1 - 3.2, filed 3/23/60, amended by General Order 3, Rule 5.1, filed 10/29/65. Formerly WAC 296-12-050.]

WAC 263-12-059 Appeals arising under the Washington Industrial Safety and Health Act—Notice to interested employees. In the case of any appeal by an employer concerning an alleged violation of the Washington Industrial Safety and Health Act, the employer shall give notice of such appeal to its employees by either: (1) providing copies of the appeal to each employee member of the employer's safety committee; or (2) by posting a copy of the appeal in a conspicuous place at the work site at which the alleged violation occurred. Any posting shall remain during the pendency of the appeal.

The employer shall also provide notice advising interested employees that an appeal has been filed with the board and that any employee or group of employees who wish to participate in the appeal may do so by contacting the board. Such notice shall include the address of the board.

The employer shall file with the board a certificate of proof of compliance with this section within fourteen days of receipt of the board's notice acknowledging receipt of the appeal. If notice as required by this section is not possible the employer shall advise the board or its designee of the reasons why notice cannot be accomplished. If the board accepts the impossibility of the required notice it will prescribe the terms and conditions of a substitute notice procedure reasonably calculated to give notice to affected employees.

[Statutory Authority: RCW 51.52.020. 01-09-032, § 263-12-059, filed 4/11/01, effective 5/12/01.]

Title 275 WAC

SOCIAL AND HEALTH SERVICES, DEPARTMENT OF (INSTITUTIONS)

Chapters

Chapter 275-25 WAC

COUNTY PLAN FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES

WAC

275-25-500 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

275-25-500 Developmental disabilities program—WAC section numbers. [Order 1142, § 275-25-500, filed 8/12/76. Formerly chapter 275-29 WAC.] Repealed by 01-15-077, filed 7/17/01, effective 8/17/01. Statutory Authority: RCW 34.05.354.

WAC 275-25-500 Repealed. See Disposition Table at beginning of this chapter.

Title 284 WAC

INSURANCE COMMISSIONER, OFFICE OF THE

Chapters

Chapter 284-04 WAC
PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION

WAC

WAC 284-04-120 Definitions. As used in this chapter, unless the context requires otherwise:

(1) "Affiliate" means any company that controls, is controlled by or is under common control with another company.

(2) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

Examples.

(a) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

(i) Presents the information in the notice in clear, concise sentences, paragraphs, and sections;

(ii) Uses short explanatory sentences or bullet lists whenever possible;

(iii) Uses definite, concrete, everyday words and active voice whenever possible;

(iv) Avoids multiple negatives;

(v) Avoids legal and highly technical business terminology whenever possible; and

(vi) Avoids explanations that are imprecise and readily subject to different interpretations.

(b) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

(i) Uses a plain-language heading to call attention to the notice;

(ii) Uses a typeface and type size that are easy to read;

(iii) Provides wide margins and ample line spacing;

(iv) Uses boldface or italics for key words; and

(v) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(c) Notices on websites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the website (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

(i) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(ii) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature, and relevance of the notice.

(3) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(4) "Commissioner" means the insurance commissioner of the state.

(5) "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

(6) "Consumer" means an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes and about whom the licensee has nonpublic personal information, or that individual's legal representative.

Examples.

(a) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(b) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(c) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(d) An individual is a licensee's consumer if:

(i) The individual is a beneficiary of a life insurance policy underwritten by the licensee;

(ii) The individual is a claimant under an insurance policy issued by the licensee;

(iii) The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(iv) The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(v) The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party

other than as permitted under WAC 284-04-400, 284-04-405, and 284-04-410.

(e) Provided that the licensee provides the initial, annual and revised notices under WAC 284-04-200, 284-04-205, and 284-04-220 to the plan sponsor, group or blanket insurance policy holder or group annuity contract holder, workers' compensation plan participant and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under WAC 284-04-400, 284-04-405, and 284-04-410, an individual is not the consumer of such licensee solely because he or she is:

(i) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

(ii) Covered under a group or blanket insurance policy or annuity contract issued by the licensee; or

(iii) A beneficiary in a workers' compensation plan.

(f) The individuals described in (e)(i) through (iii) of this subsection are consumers of a licensee if the licensee does not meet all the conditions of (e) of this subsection.

(g) In no event shall such individuals, solely by virtue of the status described in (e)(i) through (iii) of this subsection, be deemed to be customers for purposes of this chapter.

(i) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

(ii) An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

(7) "Consumer reporting agency" has the same meaning as in section 603(f) of the Federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

(8) "Control" means:

(a) Ownership, control or power to vote twenty-five percent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(b) Control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

(c) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

(9) "Customer" means a consumer who has a customer relationship with a licensee.

(10) "Customer relationship" means continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

Examples.

(a) A consumer has a continuing relationship with a licensee if:

(i) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(ii) The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

(b) A consumer does not have a continuing relationship with a licensee if:

(i) The consumer applies for insurance but does not purchase the insurance;

(ii) The licensee sells the consumer airline travel insurance in an isolated transaction;

(iii) The individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(iv) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(v) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(vi) The customer's policy is lapsed, expired, paid up or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of state or federal authority or promotional materials;

(vii) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(viii) For the purposes of this chapter, if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(11) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(a) Financial institution does not include:

(i) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 et seq.);

(ii) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.); or

(iii) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as such institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

(12) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

Financial service includes a financial institution's evaluation or brokerage of information that the financial institution

collects in connection with a request or an application from a consumer for a financial product or service.

(13) "Health care" means: Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that:

(a) Relates to the physical, mental or behavioral condition of an individual; or

(b) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs or any other tissue; or

(c) Prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

(14) "Health care provider" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law or a health care facility.

(15) "Health information" means any information or data, except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(a) The past, present or future physical, mental or behavioral health or condition of an individual;

(b) The provision of health care to an individual; or

(c) Payment for the provision of health care to an individual.

(16) "Insurer" includes health care service contractor, HMO, and fraternal benefit society.

(17) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

Insurance service includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

(18) "Licensee" means all licensed insurers, health care service contractors, HMO's, and fraternal benefit societies, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the insurance law of this state.

(a) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in WAC 284-04-100 through 284-04-400 if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

(i) The principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and

(ii) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

(b)(i) Subject to (b)(ii) of this subsection, "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to section [insert section] of this state's laws.

(ii) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in WAC 284-04-100 through 284-04-400 provided:

(A) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under WAC 284-04-405, except as permitted by WAC 284-04-410 and 284-04-415; and

(B) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW"

(19) "Licensee" shall also include an unauthorized insurer that places business through a licensed excess line broker in this state, but only in regard to the excess line placements placed pursuant to of this state's laws.

(20) "Nonaffiliated third party" means any person except:

(a) A licensee's affiliate; or

(b) A person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the Federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I.))

(21) "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

(22)(a) "Nonpublic personal financial information" means:

(i) Personally identifiable financial information; and

(ii) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available.

(b) Nonpublic personal financial information does not include:

(i) Health information;

(ii) Publicly available information, except as included on a list described in (a)(i) of this subsection; or

(iii) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

Examples of lists.

Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

(23) "Nonpublic personal health information" means health information:

(a) That identifies an individual who is the subject of the information; or

(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(24) "Personally identifiable financial information" means any information:

(a) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(b) About a consumer resulting from any transaction involving an insurance product or service between a licensee and a consumer; or

(c) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

Examples.

(i) Information included. Personally identifiable financial information includes:

(A) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(B) Account balance information and payment history;

(C) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(D) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(E) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(F) Any information the licensee collects through an Internet "cookie" (an information collecting device from a web server); and

(G) Information from a consumer report.

(ii) Information not included. Personally identifiable financial information does not include:

(A) Health information;

(B) A list of names and addresses of customers of an entity that is not a financial institution; and

(C) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

(25)(a) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(i) Federal, state or local government records;

(ii) Widely distributed media; or

(iii) Disclosures to the general public that are required to be made by federal, state or local law.

(b) Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(i) That the information is of the type that is available to the general public; and

(ii) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(c) Examples.

(i) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(ii) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a website that is available to the general public on an unrestricted basis. A website is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(iii) Reasonable basis.

(A) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(B) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-120, filed 1/9/01, effective 2/9/01.]

WAC 284-04-200 Initial privacy notice to consumers required. (1) Initial notice requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(a) Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subsection (5) of this section; and

(b) Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by WAC 284-04-405 and 284-04-410;

(2) When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under subsection (1)(b) of this section if:

(a) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by WAC 284-04-405 and 284-04-410; and

The licensee does not have a customer relationship with the consumer; or

(b) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom

the notice applies and is accurate with respect to the licensee and the other institutions.

(3) When the licensee establishes a customer relationship.

(a) General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

(b) Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

(i) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(ii) Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

(4) Existing customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of subsection (1) of this section as follows:

(a) The licensee may provide a revised policy notice, under WAC 284-04-220, that covers the customer's new insurance product or service; or

(b) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subsection (1) of this section.

(5) Exceptions to allow subsequent delivery of notice.

(a) A licensee may provide the initial notice required by subsection (1)(a) of this section within a reasonable time after the licensee establishes a customer relationship if:

(i) Establishing the customer relationship is not at the customer's election; or

(ii) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(b) Examples of exceptions.

(i) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(ii) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(iii) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a website.

(6) Delivery. When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to WAC 284-04-225. If the licensee uses a short-form initial notice for noncustomers according to WAC 284-04-210(4), the licensee may deliver its privacy notice according to WAC 284-04-210 (4)(c).

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-200, filed 1/9/01, effective 2/9/01.]

WAC 284-04-205 Annual privacy notice to customers required. (1)(a) General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

(b) Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year one, the licensee shall provide an annual notice to that customer by December 31 of year two.

(2)(a) Termination of customer relationship. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

(b) Examples.

(i) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or obtains insurance services with or through the licensee.

(ii) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired, paid up or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

(iii) For the purposes of this regulation, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(iv) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

(3) Delivery. When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to WAC 284-04-225.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-205, filed 1/9/01, effective 2/9/01.]

WAC 284-04-210 Information to be included in privacy notices. (1) General rule. The initial, annual and revised privacy notices that a licensee provides under WAC 284-04-200, 284-04-205, and 284-04-220 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(a) The categories of nonpublic personal financial information that the licensee collects;

(b) The categories of nonpublic personal financial information that the licensee discloses;

(c) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under WAC 284-04-405 and 284-04-410;

(d) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under WAC 284-04-405 and 284-04-410;

(e) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under WAC 284-04-400 (and no other exception in WAC 284-04-405 and 284-04-410 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(f) An explanation of the consumer's right under WAC 284-04-300(1) to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(g) Any disclosures that the licensee makes under section 603(d)(2)(A)(iii) of the Federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(h) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(i) Any disclosure that the licensee makes under subsection (2) of this section.

(2) Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under WAC 284-04-405 and 284-04-410, the licensee is not required to list those exceptions in the initial or annual privacy notices required by WAC 284-04-200 and 284-04-205. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(3) Examples.

(a) Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(i) Information from the consumer;

(ii) Information about the consumer's transactions with the licensee or its affiliates;

(iii) Information about the consumer's transactions with nonaffiliated third parties; and

(iv) Information from a consumer reporting agency.

(b) Categories of nonpublic personal financial information a licensee discloses.

(i) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in (a) of this subsection, as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(A) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address, and social security number;

(B) Transaction information, such as information about balances, payment history, and parties to the transaction; and

(C) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(ii) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(iii) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(c) Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(i) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(ii) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(iii) A licensee also may categorize the affiliates and nonaffiliated third parties to whom it discloses nonpublic personal financial information about consumers using more detailed categories.

(d) Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in WAC 284-04-400 to a nonaffiliated third party to market products or

services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subsection (1)(e) of this section if it:

(i) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subsection (1)(b) of this section, as applicable; and

(ii) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(e) Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under WAC 284-04-405 and 284-04-410, the licensee may simply state that fact, in addition to the information it shall provide under subsections (1)(h), (i) and (2) of this section.

(f) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(i) Describes in general terms who is authorized to have access to the information; and

(ii) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(4) Short-form initial notice with opt out notice for noncustomers.

(a) A licensee may satisfy the initial notice requirements in WAC 284-04-200 (1)(b) for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in WAC 284-04-215.

(b) A short-form initial notice shall:

(i) Be clear and conspicuous;

(ii) State that the licensee's privacy notice is available upon request; and

(iii) Explain a reasonable means by which the consumer may obtain that notice.

(c) The licensee shall deliver its short-form initial notice according to WAC 284-04-225. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to WAC 284-04-225.

(d) Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(i) Provides a toll-free telephone number that the consumer may call to request the notice; or

(ii) For a consumer who conducts business in person at the licensee's office, maintain copies of the notice on hand that the licensee provides to the consumer immediately upon request.

(5) Future disclosures. The licensee's notice may include:

(a) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but do not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

(6) Sample clauses. Sample clauses illustrating some of the notice content required by this section are included in Appendix A of this regulation.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-210, filed 1/9/01, effective 2/9/01.]

WAC 284-04-215 Form of opt out notice to consumers and opt out methods. (1)(a) Form of opt out notice. If a licensee is required to provide an opt out notice under WAC 284-04-300(1), it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

(i) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(ii) That the consumer has the right to opt out of that disclosure; and

(iii) A reasonable means by which the consumer may exercise the opt out right.

(b) Examples.

(i) Adequate opt out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

(A) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in WAC 284-04-210 (1)(b) and (c), and states that the consumer can opt out of the disclosure of that information; and

(B) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(ii) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(A) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(B) Includes a reply form together with the opt out notice;

(C) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's website, if the consumer agrees to the electronic delivery of information; or

(D) Provides a toll-free telephone number that consumers may call to opt out.

(iii) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(A) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(B) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(iv) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

(2) Same form as initial notice permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with WAC 284-04-200.

(3) Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with WAC 284-04-200, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(4) Joint relationships.

(a) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer (as explained in (e) of this subsection).

(b) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(i) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(ii) Permit each joint consumer to opt out separately.

(c) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(d) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(e) Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

(i) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(ii) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(iii) Permit John and Mary to make different opt out directions. If the licensee does so:

(A) It shall permit John and Mary to opt out for each other;

(B) If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

(C) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

(5) Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

(6) Continuing right to opt out. A consumer may exercise the right to opt out at any time.

(7) Duration of consumer's opt out direction.

(a) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(b) When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

(8) Delivery. When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to WAC 284-04-225.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-215, filed 1/9/01, effective 2/9/01.]

WAC 284-04-220 Revised privacy notices. (1) General rule. Except as otherwise authorized in this regulation, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under WAC 284-04-200, unless:

(a) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(b) The licensee has provided to the consumer a new opt out notice;

(c) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(d) The consumer does not opt out.

(2) Examples.

(a) Except as otherwise permitted by WAC 284-04-400, 284-04-405, and 284-04-410, a licensee shall provide a revised notice before it:

(i) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

(ii) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

(iii) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

(b) A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

(3) Delivery. When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to WAC 284-04-225.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-220, filed 1/9/01, effective 2/9/01.]

WAC 284-04-225 Delivery. (1) How to provide notices. A licensee shall provide any notices that this regulation requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

(2)(a) Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(i) Hand-delivers a printed copy of the notice to the consumer;

(ii) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(iii) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(iv) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(b) Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(i) Only posts a sign in its office or generally publish advertisements of its privacy policies and practices; or

(ii) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(3) Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(a) The customer uses the licensee's website to access insurance products and services electronically and agrees to receive notices at the website and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the website; or

(b) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(4) Oral description of notice insufficient. A licensee may not provide any notice required by this regulation solely by orally explaining the notice, either in person or over the telephone.

(5) Retention or accessibility of notices for customers.

(a) For customers only, a licensee shall provide the initial notice required by WAC 284-04-200 (1)(a), the annual notice required by WAC 284-04-205(1), and the revised notice required by WAC 284-04-220 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(b) Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

(i) Hand-delivers a printed copy of the notice to the customer;

(ii) Mails a printed copy of the notice to the last known address of the customer; or

(iii) Makes its current privacy notice available on a website (or a link to another website) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the website.

(6) Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

(7) Joint relationships. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of WAC, respectively, by providing one notice to those consumers jointly.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-225, filed 1/9/01, effective 2/9/01.]

WAC 284-04-300 Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties. (1)(a) Conditions for disclosure. Except as otherwise authorized in this regulation, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(i) The licensee has provided to the consumer an initial notice as required under WAC 284-04-200;

(ii) The licensee has provided to the consumer an opt out notice as required in WAC 284-04-215;

(iii) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(iv) The consumer does not opt out.

(b) Opt out definition. Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by WAC 284-04-400, 284-04-405, and 284-04-410.

(c) Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if:

(i) By mail. The licensee mails the notices required in (a) of this subsection to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within thirty days from the date the licensee mailed the notices.

(ii) By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in (a) of this subsection electronically, and the licensee allows the customer to opt out by any reasonable means within thirty days after the date that the customer acknowl-

edges receipt of the notices in conjunction with opening the account.

(iii) Isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in (a) of this subsection at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

(2) Application of opt out to all consumers and all nonpublic personal financial information.

(a) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

(b) Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

(3) Partial opt out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-300, filed 1/9/01, effective 2/9/01.]

WAC 284-04-305 Limits on redisclosure and reuse of nonpublic personal financial information. (1)(a) Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in WAC 284-04-405 or 284-04-410, the licensee's disclosure and use of that information is limited as follows:

(i) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(ii) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(iii) The licensee may disclose and use the information pursuant to an exception in WAC 284-04-405 or 284-04-410, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(b) Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

(2)(a) Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in WAC 284-04-405 or 284-04-410, the licensee may disclose the information only:

(i) To the affiliates of the financial institution from which the licensee received the information;

(ii) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(iii) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(b) Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in WAC 284-04-405 or 284-04-410:

(i) The licensee may use that list for its own purposes; and

(ii) The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in WAC 284-04-405 or 284-04-410, such as to the licensee's attorneys or accountants.

(3) Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in WAC 284-04-405 or 284-04-410 of this regulation, the third party may disclose and use that information only as follows:

(a) The third party may disclose the information to the licensee's affiliates;

(b) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(c) The third party may disclose and use the information pursuant to an exception in WAC 284-04-405 or 284-04-410 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(4) Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in WAC 284-04-405 or 284-04-410, the third party may disclose the information only:

(a) To the licensee's affiliates;

(b) To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(c) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-305, filed 1/9/01, effective 2/9/01.]

WAC 284-04-310 Limits on sharing account number information for marketing purposes. (1) General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of

access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

(2) Exceptions. Subsection (1) of this section does not apply if a licensee discloses a policy number or similar form of access number or access code:

(a) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(b) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(c) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

(3) Examples.

(a) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(b) Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-310, filed 1/9/01, effective 2/9/01.]

WAC 284-04-400 Exception to opt out requirements for disclosure of nonpublic personal financial information for service providers and joint marketing. (1) General rule.

(a) The opt out requirements in WAC 284-04-215 and 284-04-300 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(i) Provides the initial notice in accordance with WAC 284-04-200; and

(ii) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in WAC 284-04-405 or 284-04-410 in the ordinary course of business to carry out those purposes.

(b) Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of (a)(ii) of this subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in WAC 284-04-405 or 284-04-410 in the ordinary course of business to carry out that joint marketing.

(2) Service may include joint marketing. The services a nonaffiliated third party performs for a licensee under subsection (1) of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

(3) Definition of joint agreement. For purposes of this section, joint agreement means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor an insurance product or service.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-400, filed 1/9/01, effective 2/9/01.]

WAC 284-04-405 Exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions. (1) Exceptions for processing transactions at consumer's request. The requirements for initial notice in WAC 284-04-200 (1)(b), the opt out in WAC 284-04-215 and 284-04-300 and service providers and joint marketing in WAC 284-04-400 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

(a) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(b) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

(c) A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

(d) Reinsurance or stop loss or excess loss insurance.

(2) Necessary to effect, administer or enforce a transaction means that the disclosure is:

(a) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(b) Required, or is a usual, appropriate or acceptable method:

(i) To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(ii) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(iii) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(iv) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(v) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: Account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims,

administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(vi) In connection with:

(A) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

(B) The transfer of receivables, accounts or interests therein; or

(C) The audit of debit, credit or other payment information.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-405, filed 1/9/01, effective 2/9/01.]

WAC 284-04-410 Other exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information. (1) Exceptions to opt out requirements. The requirements for initial notice to consumers in WAC 284-04-200 (1)(b), the opt out in WAC 284-04-215 and 284-04-300, and service providers and joint marketing in WAC 284-04-400 do not apply when a licensee discloses nonpublic personal financial information:

(a) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(b)(i) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;

(ii) To protect against or prevent actual or potential fraud or unauthorized transactions;

(iii) For required institutional risk control or for resolving consumer disputes or inquiries;

(iv) To persons holding a legal or beneficial interest relating to the consumer; or

(v) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(c) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

(d) To the extent specifically permitted or required under other provisions of law and in accordance with the Federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission), the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

(e)(i) To a consumer reporting agency in accordance with the Federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or

(ii) From a consumer report reported by a consumer reporting agency;

(f) In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit; or

(g)(i) To comply with federal, state or local laws, rules and other applicable legal requirements;

(ii) To comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities;

(iii) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

(h) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan.

(2) Example of revocation of consent. A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under WAC 284-04-215(6).

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-410, filed 1/9/01, effective 2/9/01.]

WAC 284-04-500 Health information privacy policies and procedures. All licensees shall develop and implement written policies, standards and procedures for the management of health information, including policies, standards and procedures to guard against the unauthorized collection, use or disclosure of nonpublic personal health information by the licensee consistent with regulations adopted by the U.S. Department of Health and Human Services governing health information privacy (45 CFR 160 through 164) which shall include:

(1) Limitation on access to health information by only those persons who need to use the health information in order to perform their jobs;

(2) Appropriate training for all employees;

(3) Disciplinary measures for violations of the health information policies, standards and procedures;

(4) Identification of the job titles and job descriptions of persons that are authorized to disclose nonpublic personal health information;

(5) Procedures for authorizing and restricting the collection, use or disclosure of nonpublic personal health information;

(6) Methods for exercising the right to access and amend incorrect nonpublic personal health information;

(7) Methods for handling, disclosing, storing and disposing of health information;

(8) Periodic monitoring of the employee's compliance with the licensee's policies, standards and procedures in a manner sufficient for the licensee to determine compliance and to enforce its policies, standards and procedures; and

(9) Methods for informing and allowing an individual who is the subject of nonpublic personal health information to request specialized disclosure or nondisclosure of nonpublic personal health information as required in this chapter.

(10) A licensee shall make the health information policies, standards and procedures developed pursuant to this section available for review by the commissioner.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-500, filed 1/9/01, effective 2/9/01.]

WAC 284-04-505 Nonpublic personal health information—When authorization required. (1) A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

(2) Except as provided in WAC 284-04-510, nothing in this section shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of insurance functions by or on behalf of the licensee, for activities permitted under RCW 70.02.050, and for activities permitted under health privacy regulations adopted by the U.S. Department of Health and Human Services governing health information privacy.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-505, filed 1/9/01, effective 2/9/01.]

WAC 284-04-510 Right to limit disclosure of health information. (1) Notwithstanding other provisions of this chapter, a licensee shall limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual. Disclosure of information under this subsection shall be limited consistent with the individual's request, such as a request for the licensee to not release any information to a spouse to prevent domestic violence.

(2) Notwithstanding any insurance law requiring the disclosure of information, a licensee shall not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, chemical dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or certificateholder, if the individual who is the subject of the information makes a written request. In addition, a licensee shall not require an adult individual to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim.

(3)(a) A licensee shall recognize the right of any minor who may obtain health care without the consent of a parent or legal guardian pursuant to state or federal law, to exclusively exercise rights granted under this section regarding health information; and

(b) Shall not disclose any nonpublic personal health information related to any health care service to which the minor has lawfully consented, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or other covered person, without the express authorization of the minor. In addition, a licensee shall not require the minor to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim as to health care which the minor may obtain without parental consent under state or federal law.

(4) When requesting nondisclosure, the individual shall include in the request:

(a) Their name and address;

(b) Description of the type of information that should not be disclosed;

(c) In the case of reproductive health information, the type of services subject to nondisclosure;

(d) The identity or description of the types of persons from whom information should be withheld;

(e) Information as to how payment will be made for any benefit cost sharing;

(f) A phone number or e-mail address where the individual may be reached if additional information or clarification is necessary to satisfy the request.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-510, filed 1/9/01, effective 2/9/01.]

WAC 284-04-515 Authorizations. (1) A valid authorization to disclose nonpublic personal health information pursuant to this Article V shall be in written or electronic form and shall contain all of the following:

(a) The identity of the consumer or customer who is the subject of the nonpublic personal health information.

(b) A general description of the types of nonpublic personal health information to be disclosed.

(c) General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used.

(d) The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed.

(e) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making such a revocation.

(2) An authorization for the purposes of this Article V shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four months.

(3) A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to this Article V at any time, subject to the rights of any individual who acted in reliance on the authorization prior to notice of the revocation.

(4) A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

(5) Notwithstanding the provisions of this section, a licensee complying with regulations adopted by the U.S.

Department of Health and Human Services governing authorization for the release of health information satisfies the provisions of this section.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-515, filed 1/9/01, effective 2/9/01.]

WAC 284-04-520 Authorization request delivery. A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to WAC 284-04-225, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to WAC 284-04-500(1).

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-520, filed 1/9/01, effective 2/9/01.]

WAC 284-04-525 Relationship to state and federal laws. In the event of a conflict between this chapter and the state or federal laws, licensees shall comply with the state and federal laws governing privacy, as such laws relate to the business of insurance, except as expressly required by this chapter.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-525, filed 1/9/01, effective 2/9/01.]

WAC 284-04-600 Protection of Fair Credit Reporting Act. Nothing in this regulation shall be construed to modify, limit or supersede the operation of the Federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under section 603 of that act.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-600, filed 1/9/01, effective 2/9/01.]

WAC 284-04-605 Nondiscrimination. (1) A licensee shall not discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

(2) A licensee shall not discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the provisions of this regulation.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-605, filed 1/9/01, effective 2/9/01.]

WAC 284-04-610 Violation. A violation of this regulation shall be deemed to be an unfair method of competition or an unfair or deceptive act and practice in this state.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-610, filed 1/9/01, effective 2/9/01.]

WAC 284-04-615 Severability. If any section or portion of a section of this regulation or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-615, filed 1/9/01, effective 2/9/01.]

WAC 284-04-620 Effective date; transition rule. (1) Effective date. These rules are effective July 1, 2001.

(2)(a) Notice requirement for consumers who are the licensee's customers on the compliance date. By July 1, 2001, a licensee shall provide an initial notice, as required by WAC 284-04-200, to consumers who are the licensee's customers on July 1, 2001.

(b) Example. A licensee provides an initial notice to consumers who are its customers on July 1, 2001, if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

(3) Two-year grandfathering of service agreements. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of WAC 284-04-400 (1)(a)(ii), even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before January 9, 2001.

(4) With respect to nonpublic personal health information under WAC 284-04-510, these rules are effective December 30, 2002.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-620, filed 1/9/01, effective 2/9/01.]

WAC 284-04-900 Sample clauses. Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the Federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1—Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(a) to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

A-2—Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of WAC 284-04-210 (1)(b) to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, Social Security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premiums, and payment history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described (describe location in the notice, such as "above" or "below").

A-3—Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of WAC 284-04-210 (1)(b), (c), and (d) to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in WAC 284-04-405 and 284-04-410.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4—Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(c) to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410, as well as when permitted by the exceptions in WAC 284-04-405 and 284-04-410.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as (provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents");
- Nonfinancial companies, such as (provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"); and
- Others, such as (provide illustrative examples, such as "nonprofit organizations").

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5—Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of WAC 284-04-210 (1)(e) related to the exception for service providers and joint marketers in WAC 284-04-400. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with whom the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, Social Security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premium, and payment history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described (describe location in the notice, such as "above" or "below") to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6—Explanation of opt out right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(f) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permit-

ted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may (describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)).

A-7—Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(h) to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to (provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"). We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-900, filed 1/9/01, effective 2/9/01.]

Chapter 284-07 WAC
REQUIREMENTS AS TO COMPANY REPORTS AND ANNUAL STATEMENTS

WAC

WAC 284-07-050 Annual statement instructions. (1) For the purpose of this section, the following definitions shall apply:

(a) "Insurer" shall have the same meaning as set forth in RCW 48.01.050. It also includes health care service contractors registered under chapter 48.44 RCW and health maintenance organizations registered under chapter 48.46 RCW.

(b) "Insurance" shall have the same meaning as set forth in RCW 48.01.040. It also includes prepayment of health care services as set forth in RCW 48.44.010(3) and prepayment of comprehensive health care services as set forth in RCW 48.46.020(1).

(2) Each authorized insurer is required to file with the commissioner an annual statement for the previous calendar year in the general form and context as promulgated by the National Association of Insurance Commissioners (NAIC) for the kinds of insurance to be reported upon, and shall also file a copy thereof with the NAIC. To effectuate RCW 48.05.250, 48.05.400, 48.44.095 and 48.46.080 and to enhance consistency in the accounting treatment accorded various kinds of insurance transactions, the valuation of assets, and related matters, insurers shall adhere to the appropriate Annual Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC.

(3) This section does not relieve an insurer from its obligation to comply with specific requirements of the insurance code or rules thereunder.

(4) Number of statements:

(a) For domestic insurers, the statements are to be filed in triplicate to assist with public viewing and copying. Two statements must be permanently bound on the left side. The third statement must be unbound. The statements are to be filed in the Olympia office.

(b) For foreign insurers, except for health care service contractors and health maintenance organizations, one statement shall be filed in the Olympia office. For health care service contractors and health maintenance organizations, two left side permanently bound and one unbound statement shall be filed in the Olympia office to assist with public viewing and copying.

(5) Each domestic insurer shall file quarterly reports of its financial condition with the commissioner and with the NAIC. Each foreign insurer shall file quarterly reports of its financial condition with the NAIC. The commissioner may require a foreign insurer to file quarterly reports with the commissioner whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the foreign insurer. The reports shall be filed in the commissioner's office not later than the forty-fifth day after the end of the insurer's calendar quarters. Such quarterly reports shall be in the form and content as promulgated by the NAIC for quarterly reporting by insurers, shall be prepared according to appropriate Annual and Quarterly Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC and shall be supplemented with additional information required by this title and by the commissioner. The statement is to be completed and filed in the same manner and places as the annual statement. Quarterly reports for the fourth quarter are not required.

(6) As a part of any investigation by the commissioner, the commissioner may require an insurer to file monthly financial reports whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the insurer. Monthly financial statements shall be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial report is being filed. Such monthly financial reports shall be the internal financial statements of the company. In addition, the commissioner may require these internal financial statements to be accompanied by a schedule converting the financial statements to reflect financial position according to statutory accounting practices and submitted in a form using the same format and designation as the insurer's quarterly financial reports of insurers.

(7) Health care service contractors shall use the Hospital, Medical, Dental Service or Indemnity Corporation's Statement Form promulgated by the NAIC for their statutory filings.

(8) Each health care service contractor's and health maintenance organization's annual statement shall be accompanied by a monthly enrollment data form (IC-16-HC/IC-15-HMO) and additional data statement form (IC-13A-HC/IC-14-HMO).

(9) An insurer who on December 31, 1996, has not previously filed its annual or quarterly statements with the NAIC, shall comply with this rule for the year ending December 31, 1996, and each year thereafter. To enhance the intrastate and interstate surveillance of the insurer's financial condition earlier application is permitted.

(10) The commissioner may allow a reasonable extension of the time within which such financial statements shall be filed.

[Statutory Authority: RCW 48.02.060, 48.05.073, 48.44.050, 48.46.200. 01-11-077 (Matter No. R 2000-09), § 284-07-050, filed 5/15/01, effective 6/15/01. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 99-16-035 (Matter No. R - 99-3), § 284-07-050, filed 7/28/99, effective 8/28/99;96-17-079 (Matter No. R 95-18), § 284-07-050, filed 8/21/96, effective 9/21/96. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-050, filed 9/9/92, effective 10/10/92.]

WAC 284-07-130 Contents of annual audited financial report. (1) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the commissioner.

(2) The annual audited financial report shall include the following:

(a) Report of independent certified public accountant.

(b) Balance sheet reporting admitted assets, liabilities, capital, and surplus.

(c) Statement of operations.

(d) Statement of cash flows.

(e) Statement of changes in capital and surplus.

(f) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and *NAIC Accounting Practices and Procedures Manual*. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to RCW 48.05.250, 48.05.073, 48.43.050, 48.43.097[,] 48.44.095, or 48.46.080 with a written description of the nature of these differences.

(g) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statements shall be comparative, presenting the amounts as of December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

[Statutory Authority: RCW 48.02.060, 48.05.073, 48.43.097, 48.44.050, 48.46.200. 01-21-075 (Matter No. R 2001-03), § 284-07-130, filed 10/18/01, effective 11/18/01. Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-130, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-130, filed 9/9/92, effective 10/10/92.]

Chapter 284-24 WAC
RATES

WAC

284-24-120 Suspension of rate filing requirements—Large commercial accounts.

WAC 284-24-120 Suspension of rate filing requirements—Large commercial accounts. (1) Under RCW 48.19.080, the rate filing requirements in chapter 48.19 RCW are suspended with respect to large commercial property casualty accounts.

(2) For purposes of this section, "large commercial property casualty account" means insurance coverage that:

(a) Pertains to a business, nonprofit organization, or public entity;

(b) Involves the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, 48.11.070, and/or 48.11.080; and

(c) Has an estimated annual collected premium of $25,000 or more, excluding workers compensation insurance issued by the department of labor and industries and types of insurance listed in subsection (6) of this section.

(3) Before an insurer issues coverage in reliance on this section, the insurer or its agent shall notify the insured in writing that the rates have not been and will not be filed for the commissioner's approval.

(4) Property rates used on large commercial property casualty accounts will not be audited by the Washington Insurance Examining Bureau under WAC 284-20-006.

(5) The commissioner retains the right and ability to examine the rates used on large commercial property casualty accounts to ascertain whether they meet the requirements of RCW 48.19.020 and other statutes. The insurer shall maintain records supporting the rating and premium determination of each policy issued in reliance on this section. These records shall be retained by the insurer for a minimum of three years and made available at all reasonable times for the commissioner's examination.

(6) Subsection (1) of this section does not apply to:

(a) Professional liability insurance, including medical malpractice insurance;

(b) Directors' and officers' liability insurance purchased by individuals;

(c) Motor vehicle service contract reimbursement insurance, as defined in RCW 48.96.010(4); and

(d) Master policies under which certificates of coverage are issued to individual consumers, households, businesses, or other organizations.

(7) If this subsection is not amended, the provisions of this section shall expire on December 31, 2003.

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.19.080. 02-02-068 (Order R 2001-09), § 284-24-120, filed 12/28/01, effective 12/31/01. Statutory Authority: RCW 48.02.060 and 48.19.080. 99-23-068 (Matter No. R 99-5), § 284-24-120, filed 11/15/99, effective 12/16/99.]

Chapter 284-43 WAC
HEALTH CARRIERS AND HEALTH PLANS

WAC

284-43-130 Definitions.

284-43-200 Network adequacy.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-43-610 Definitions. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-43-610, filed 11/29/99, effective 12/30/99.] Repealed by 01-03-033 (Matter No. R 2000-02), filed 1/9/01, effective 7/1/01. 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.

284-43-821 Maternity and pregnancy-related exclusions, limitations and conditions in individual plans. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. 01-03-035 (Matter No. R 2000-03), § 284-43-821, filed 1/9/01, effective 7/1/01.] Repealed by 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.

284-43-823 Maternity and pregnancy-related exclusions, limitations and conditions in group plans. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. 01-03-035 (Matter No. R 2000-03), § 284-43-823, filed 1/9/01, effective 7/1/01.] Repealed by 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.

284-43-824 Effective date. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. 01-03-035 (Matter No. R 2000-03), § 284-43-824, filed 1/9/01, effective 2/9/01.] Repealed by 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination and noncertification" means a decision by a health carrier to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

(2) "Certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" means an individual covered by a health plan including an enrollee, subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" means a written or an oral complaint submitted by or on behalf of a covered person regarding:

(a) Denial of health care services or payment for health care services; or

(b) Issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020.

(15) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(16) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(17) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit if the service is consistent with generally recognized standards within a relevant health profession.

(18) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(19) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(20) "Network" means the group of participating providers and facilities providing health care services to a particular health plan. A health plan network for carriers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(21) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology,* published by the American Medical Association.

(22) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(23) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(24) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(25) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(26) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(27) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(28) "Small group" means a health plan issued to a small employer as defined under RCW 48.43.005(24) comprising from one to fifty eligible employees.

(29) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(30) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-130, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. 01-03-032 (Matter No. R 2000-04), § 284-43-130, filed 1/9/01, effective 2/9/01. Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. 99-19-032 (Matter No. R 98-7), § 284-43-130, filed 9/8/99, effective 10/9/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-130, filed 1/22/98, effective 2/22/98.]

WAC 284-43-200 Network adequacy. (1) A health carrier shall maintain each plan network in a manner that is

sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider, including those types of providers who must be included in the network under WAC 284-43-205. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's service area shall not be created in a manner designed to discriminate against persons because of age, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter.

(2) Sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.

(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.

(4) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. Health carriers shall make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees. In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.

(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.

(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.

(7) To provide adequate choice to covered persons who are American Indians, each health carrier shall maintain arrangements that ensure that American Indians who are covered persons have access to Indian health care services and facilities that are part of the Indian health system. Carriers shall ensure that such covered persons may obtain covered services from the Indian health system at no greater cost to the covered person than if the service were obtained from network providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits a carrier from limiting coverage to those health services that meet carrier standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-200, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-200, filed 1/24/00, effective 3/1/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-200, filed 1/22/98, effective 2/22/98.]

WAC 284-43-251 Covered person's access to providers. (1) Each carrier must allow a covered person to choose a primary care provider who is accepting new patients from a list of participating providers. Covered persons also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the covered person's request for the change.

(2) Each carrier must have a process whereby a covered person with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time. The standing referral must be consistent with the covered person's medical 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 carrier performance of utilization review functions.

(3) Each carrier shall provide covered persons with direct access to the participating chiropractor of the covered

person's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting covered persons to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. 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.

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

(5) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the covered persons or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Notice to covered persons shall include information of the covered person's right of access to the terminating provider for an additional sixty days. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new covered persons to the terminated provider.

(6) Each carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-251, filed 1/9/01, effective 7/1/01.]

WAC 284-43-410 Utilization review—Generally. (1) Each carrier shall maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical review criteria available upon request to participating providers. A carrier need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

(2) The utilization review program shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter and shall have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(3) Each carrier when conducting utilization review shall:

(a) Accept information from any reasonably reliable source that will assist in the certification process;

(b) Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

(c) Not routinely require providers or facilities to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;

(d) Not routinely request copies of medical records on all patients reviewed;

(e) Require only the section(s) of the medical record during prospective review or concurrent review necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service;

(f) For prospective and concurrent review, base review determinations solely on the medical information obtained by the carrier at the time of the review determination;

(g) For retrospective review, base review determinations solely on the medical information available to the attending physician or order provider at the time the health service was provided;

(h) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider;

(i) Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol; and

(j) Reverse its certification determination only when information provided to the carrier is materially different from that which was reasonably available at the time of the original determination.

(4) Each carrier shall reimburse reasonable costs of medical record duplication for reviews.

(5) Each carrier shall have written procedures to assure that reviews and second opinions are conducted in a timely manner.

(a) Review determinations must be made within two business days of receipt of the necessary information on a proposed admission or service requiring a review determination.

(b) The frequency of reviews for the extension of initial determinations must be based upon the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(c) Retrospective review determinations must be completed within thirty days of receipt of the necessary information.

(d) Notification of the determination shall be provided to the attending physician or ordering provider or facility and to the covered person within two days of the determination and shall be provided within one day of concurrent review deter-

mination. Notification shall include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

(6) No carrier may penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the carrier's determination with respect to coverage or payment for health care service.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-410, filed 1/9/01, effective 7/1/01.]

WAC 284-43-610 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-43-615 Grievance and complaint procedures—Generally. (1) Each carrier must adopt and implement a comprehensive process for the resolution of covered persons' grievances and appeals of adverse determinations. This process shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

(2) This process must conform to the provisions of this chapter and each carrier must:

(a) Provide a clear explanation of the grievance process upon request, upon enrollment to new covered persons, and annually to covered person and subcontractors of the carrier.

(b) Ensure that the grievance process is accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(c) Process as a grievance a covered person's expression of dissatisfaction about customer service or the quality or availability of a health service.

(d) Implement procedures for registering and responding to oral and written grievances in a timely and thorough manner including the notification of a covered person that a grievance or appeal has been received.

(e) Assist the covered person with all grievance and appeal processes.

(f) Cooperate with any representative authorized in writing by the covered person.

(g) Consider all information submitted by the covered person or representative.

(h) Investigate and resolve all grievances and appeals.

(i) Provide information on the covered person's right to obtain second opinions.

(j) Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-615, filed 1/9/01, effective 7/1/01.]

WAC 284-43-620 Procedures for review and appeal of adverse determinations. (1) A covered person or the covered person's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the covered person may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the covered person of its decision within fourteen days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the coverage person.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, the carrier shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating health care provider determines that delay could jeopardize the covered person's health or ability to regain maximum function, the carrier shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.

(3) A carrier may not take or threaten to take any punitive action against a provider acting on behalf or in support of a covered person appealing an adverse determination.

(4) Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease.

(5) All appeals must include a review of all relevant information submitted by the covered person or a provider acting on behalf of the covered person.

(6) The carrier shall issue to affected parties and to any provider acting on behalf of the covered person a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-620, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-43-620, filed 11/29/99, effective 12/30/99.]

WAC 284-43-630 Independent review of adverse determinations. (1) A covered person may seek review by a certified independent review organization of an adverse decision after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the covered person, or after the carrier has exceeded the timelines for grievances provided in this chapter, without good cause and without reaching a decision. Upon prior written approval of the carrier's process by the commissioner, a carrier may establish a process to bypass the carrier's internal grievance process and allow for the direct appeal to a certified independent review organization for certain classes of adverse determinations.

(2) Carriers must provide to the appropriate independent review organization certified by the department of health and designated by the commissioner's rotational registry, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the covered person that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization; including relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost-effectiveness evidence;

(c) Any documentation and written information submitted to the carrier in support of the appeal;

(d) A list of each physician or health care provider who has provided care to the covered person and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to the privacy provisions of Title 284 WAC;

(e) The attending or ordering provider's recommendations; and

(f) The terms and conditions of coverage under the relevant health plan.

The carrier shall also make available to the covered person and to any provider acting on behalf of the covered person all materials provided to an independent review organization reviewing the carrier's determination. The carrier may also require the covered person and any provider acting on behalf of a covered person to make available to the carrier information provided to an independent review organization in support of an appeal.

(3) The medical reviewers from a certified independent review organization shall make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for a covered person. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(4) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the covered person or covered person's representative.

(5) Carriers must implement the certified independent review organization's determination promptly, and must pay the certified independent review organization's charges.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-630, filed 1/9/01, effective 7/1/01.]

WAC 284-43-815 Coverage for pharmacy services. (1) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the following statement is not provided to covered persons at the time of enrollment:

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us (the health carrier) at 1-800-???-????.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

(2) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the carrier does not: Pose and respond in writing to the following questions in language that complies with WAC 284-50-010 through 284-50-230; offers to provide and provide upon request this information prior to enrollment; and ensures that this information is provided to covered persons at the time of enrollment:

(a) **"Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?"** The response must describe the process for developing coverage standards and formularies, including the principal criteria by which drugs are selected for inclusion, exclusion, restriction or limitation. If a determination of medical necessity is used, that term must be briefly defined here. Coverage standards involving the use of substitute drugs, whether generic or therapeutic, are either an exception, reduction or limitation and must be discussed here. Major categories of drugs excluded, limited or reduced from coverage may be included in this response.

(b) **"When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?"** The response must identify the process of changing formularies and coverage standards, including changes in the use of substitute drugs. If the plan gives prior notice of these changes or has provisions for "grandfathering" certain ongoing prescriptions, these practices may be discussed here.

(c) **"What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"** The response must include a phone number to call with a request for a change in coverage decisions, and must discuss the process and criteria by which such a change may be granted. The response may refer to the appeals or grievance process without describing that process in detail here. The response must state the time within which

requests for changes will be acted upon in normal circumstances and in circumstances where an emergency medical condition exists.

(d) **"How much do I have to pay to get a prescription filled?"** The response must list enrollee point-of-service cost-sharing dollar amounts or percentages for all coverage categories including at least name brand drugs, substitute drugs and any drugs which may be available, but which are not on the health plan's formulary.

(e) **"Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?"** If the answer to this question is "yes," the plan must state the approximate number of pharmacies in Washington at which the most favorable enrollee cost sharing will be provided, and some means by which the enrollee can learn which ones they are.

(f) **"How many days' supply of most medications can I get without paying another co-pay or other repeating charge?"** The response should discuss normal and exceptional supply limits, mail order arrangements and travel supply and refill requirements or guidelines.

(g) **"What other pharmacy services does my health plan cover?"** The response should include any "intellectual services," or disease management services reimbursed by the plan in addition to those required under state and federal law in connection with dispensing, such as disease management services for migraine, diabetes, smoking cessation, asthma, or lipid management.

(3) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the general categories of drugs excluded from coverage are not provided to covered persons at the time of enrollment. Such categories may include items such as appetite suppressants, dental prescriptions, cosmetic agents or most over-the-counter medications. This subsection intends only to promote clearer enrollee understanding of the exclusions, reductions and limitations contained in a health plan, and not to suggest that any particular categories of coverage for drugs or pharmacy services should be excluded, reduced, or limited by a health plan.

(4) In complying with these requirements, a carrier may, where appropriate and consistent with the provisions of these rules, consolidate the information with other material required by disclosure provisions set forth in RCW 48.43.510 and WAC 284-43-820.

(5) This information may be provided in a narrative form to the extent that the content of both questions and answers is included.

(6) The commissioner may grant an extension or waive these requirements for good cause and if there is assurance that the information, required herein, is distributed in a timely manner consistent with the purpose and intent of these rules.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. 01-03-032 (Matter No. R 2000-04), § 284-43-815, filed 1/9/01, effective 2/9/01.]

WAC 284-43-820 Health plan disclosures—Prescription drugs, preventive care, generally. (1) A carrier that offers a health plan may not offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative without first offering to provide, and providing upon request, the following information using a standardized summary format filed with the commissioner and consistent with WAC 284-43-815 before purchase or selection:

(a) A listing of covered benefits, including prescription drug benefits, if any, and how consumers may be involved in decisions about benefits;

(b) A listing of exclusions, reductions, and limitations to covered benefits, including definitions of terms such as formulary, generic versus brand name, medical necessity or other coverage criteria and policies regarding coverage of drugs, including how drugs are added or removed from the formulary;

(c) A statement of the carrier's policies for protecting the confidentiality of health information;

(d) A statement of the cost of premiums and any enrollee cost-sharing requirements;

(e) A summary explanation of the carrier's grievance process;

(f) A statement regarding the availability of a point-of-service option, if any, and how the option operates; and

(g) A convenient means of obtaining a complete and detailed list of covered benefits including a copy of the current formulary, if any is used, a list of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. The offer to provide the information referenced in this subsection (1) must be clearly and prominently displayed on any information provided to any prospective enrollee or to any prospective group representative, agent, employer, or enrollee representative.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a carrier must provide written information regarding any health care plan it offers, that includes the following written information:

(a) Any documents, instruments, or other information referred to in the medical coverage agreement;

(b) A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral;

(c) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;

(d) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider or network;

(e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

(f) An annual accounting of all payments made by the carrier which have been counted against any payment limita-

tions, visit limitations, or other overall limitations on a person's coverage under a plan;

(g) A copy of the carrier's grievance process for claim or service denial and for dissatisfaction with care; and

(h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

(3) Each carrier shall provide to all enrollees and prospective enrollees a list of available disclosure items.

(4) Nothing in this section requires a carrier or a health care provider to divulge proprietary information to an enrollee, including the specific contractual terms and conditions between a carrier and a particular provider.

(5) No carrier may advertise or market any health plan to the public, including to any employer as a plan that covers services that help prevent illness or promote the health of enrollees unless it:

(a) Provides all clinical preventive health services provided by the basic health plan, authorized by chapter 70.47 RCW;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health plan. Standardized measures for this purpose, include HEDIS, consumer assessment of health plans (CAHP) or other national standardized measurement systems adopted by national managed care accreditation organizations or state agencies that purchase managed health care services and approved by the commissioner; and

(c) Makes available upon request to enrollees its integrated plan to identify and manage the most prevalent diseases within its enrolled population, including cancer, heart disease, and stroke. Such plans must include means to identify enrollees with these diseases, implement evidence based screening, education, monitoring and treatment protocols, track patient and provider adherence to these protocols, measure health outcomes, and regularly report results to enrollees.

(6) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's medical coverage agreement with the carrier. No carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

(7) No carrier may preclude or discourage enrollees or those paying for their coverage from discussing the comparative merits of different carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

(8) Each carrier must communicate enrollee information required in this act by means that ensure that a substantial portion of the enrollee population can make use of the information.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-820, filed 1/9/01, effective 7/1/01.]

WAC 284-43-821 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-43-822 Unfair practice relating to health coverage. (1) It is an unfair practice for any health carrier to restrict, exclude, or reduce coverage or benefits under any health plan on the basis of sex. By way of example, a health plan providing generally comprehensive coverage of prescription drugs and prescription devices restricts, excludes, or reduces coverage or benefits on the basis of sex if it fails to provide prescription contraceptive coverage that complies with this regulation.

An example of a plan that provides generally comprehensive coverage of prescription drugs is a plan that covers prescription drugs but excludes some categories such as weight reduction or smoking cessation.

(2)(a) Health plans providing generally comprehensive coverage of prescription drugs and/or prescription devices shall not exclude prescription contraceptives or cover prescription contraceptives on a less favorable basis than other covered prescription drugs and prescription devices. Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.

(b) Health plans may not impose benefit waiting periods, limitations, or restrictions on prescription contraceptives that are not required or imposed on other covered prescription drugs and prescription devices.

(c) Health plans may require cost sharing, such as copayments or deductibles, for prescription contraceptives and for services associated with the prescribing, dispensing, delivery, distribution, administration, and removal of the prescription contraceptives, to the same extent that such cost sharing is required for other covered prescription drugs, devices or services.

(d) Health carriers may use, and health plans may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception as defined in (f) of this subsection.

(e) If a health plan excludes coverage for nonprescription drugs and devices except for those required by law, it may also exclude coverage for nonprescription contraceptive drugs and devices.

(f) For purposes of subsections (1) and (2) of this section, "prescription contraceptives" include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.

(g) This section applies prospectively to health plans offered, issued, or renewed by a health carrier on or after January 1, 2002.

[Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220. 01-19-001 (Matter No. R 2001-02), § 284-43-822, filed 9/5/01, effective 10/6/01.]

WAC 284-43-823 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-43-824 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-43-899 Effective date. The effective date of WAC 284-43-130, 284-43-200, 284-43-251, 284-43-400, 284-43-410, 284-43-610, 284-43-615, 284-43-620, 284-43-630, and 284-43-820 is July 1, 2001.

[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. 01-03-033 (Matter No. R 2000-02), § 284-43-899, filed 1/9/01, effective 2/9/01.]

Title 286 WAC

INTERAGENCY COMMITTEE FOR OUTDOOR RECREATION

Chapters

Chapter 286-06 WAC
PUBLIC RECORDS

WAC

WAC 286-06-045 Committee and the salmon recovery funding board. The committee provides support to the salmon recovery funding board, as directed in RCW 79A.25.240, including administration and management of the salmon board's public records. Such records shall be managed and made available through the committee's public records officer in the same manner as provided for committee records and set forth in this chapter.

[Statutory Authority: RCW 34.05.370, 46.09.240(1), 79A.25.210, 79A.15.070, 79A.25.080, chapter 42.17 RCW. 01-17-056, § 286-06-045, filed 8/14/01, effective 9/14/01.]

WAC 286-06-050 Public records available. All public records of the committee and board, as defined in RCW 42.17.260, as now or hereafter amended, are available for public inspection and copying pursuant to this regulation, except as otherwise provided by law, including, but not limited to, RCW 42.17.255 and 42.17.310 and WAC 286-06-100 - Exemptions.

[Statutory Authority: RCW 34.05.370, 46.09.240(1), 79A.25.210, 79A.15.070, 79A.25.080, chapter 42.17 RCW. 01-17-056, § 286-06-050, filed 8/14/01, effective 9/14/01. Statutory Authority: RCW 43.98A.060(1), [43.98A].070(5), 43.99.080, 46.09.240 and 77.12.720. 94-17-095, § 286-06-050, filed 8/17/94, effective 9/17/94. Statutory Authority: RCW 43.99.010, 43.99.110, 43.99.080, 43.99.120, 43.99.060, 42.17.370, 46.09.020, 46.09.170 and 46.09.240. 83-01-030 (Order IAC 82-1), § 286-06-050, filed 12/8/82; Order 73-4, § 286-06-050, filed 12/19/73.]

WAC 286-06-060 Responsibility. The public records shall be available through a public records officer designated by the director. The public records officer shall be responsible for: Implementation of the rules and regulations regarding release of public records, coordinating the staff of the committee in this regard, and generally ensuring compliance with the public records disclosure requirements of chapter 42.17 RCW as now or hereafter amended.

[Statutory Authority: RCW 34.05.370, 46.09.240(1), 79A.25.210, 79A.15.070, 79A.25.080, chapter 42.17 RCW. 01-17-056, § 286-06-060, filed 8/14/01, effective 9/14/01. Statutory Authority: RCW 43.98A.060(1), [43.98A].070(5), 43.99.080, 46.09.240 and 77.12.720. 94-17-095, § 286-06-060, filed 8/17/94, effective 9/17/94. Statutory Authority: RCW 43.99.010, 43.99.110, 43.99.080, 43.99.120, 43.99.060, 42.17.370, 46.09.020, 46.09.170 and 46.09.240. 83-01-030 (Order IAC 82-1), § 286-06-060, filed 12/8/82. Statutory Authority: Chapter 43.99 RCW. 78-03-032 (Order 78-1), § 286-06-060, filed 2/17/78; Order 73-4, § 286-06-060, filed 12/19/73.]

WAC 286-06-065 Indexes. (1) Through its public records officer, the committee shall maintain indexes for the records and files listed in subsection (2)(a) through (g) of this section. These indexes:

(a) Provide identifying information as to its files and records;

(b) Are available for public inspection and copying at its offices in the Natural Resources Building, Olympia, in the manner provided in this chapter for the inspection and copying of public records;

(c) Are updated at least every five years and revised at appropriate intervals;

(d) Are public records even if the records to which they refer may not, in all instances, be subject to disclosure.

(2) Indexes of the following records and files are available:

(a) Archived files;

(b) Equipment inventory;

(c) Committee and board policies and procedures, including manuals;

(d) Active project files;

(e) Publications such as brochures and special reports;

(f) Policy statements entered after June 30, 1990, as defined in RCW 34.05.010(15), including grant program manuals;