Title 55 WAC
BASIC HEALTH PLAN

Chapters

Chapter 55-01 WAC
WASHINGTON BASIC HEALTH PLAN

WAC

WAC 55-01-001 Authority. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

[Statutory Authority: RCW 70.47.050. 88-24-030 (Order 88-001), § 55-01-001, filed 12/2/88.]

WAC 55-01-010 Definitions. The following definitions apply throughout these rules.

(1) "Administrator" means the Washington basic health plan administrator.

(2) "Certificate of coverage" means a written document issued by the plan to a subscriber which describes the covered services, premiums, grievance procedures and other rights and responsibilities of enrollees. The certificate of coverage issued to a subscriber shall pertain to the subscriber and family dependents.

(3) "Copayment" means a payment indicated in the schedule of benefits which is made by an enrollee to a managed health care system or health care provider, or to the plan, when specifically instructed to do so by the plan, for covered services provided to the enrollee.

(4) "Covered services" means those services and benefits to which an enrollee is entitled, under the certificate of coverage issued by the plan to the enrollee (or to a subscriber on behalf of the enrollee), in exchange for payment of premium and applicable copayments.

(5) "Dependent child" means an individual's unmarried natural child, stepchild, or legally adopted child, who is either (a) younger than age nineteen, or (b) younger than age twenty-three and (i) is a full-time student at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, or (ii) is pursuing a full-time course of institutional on-farm training under the supervision of an educational organization described in WAC 55-01-010 (5)(b)(i).

(6) "Effective date of enrollment" means the first date, as established by the plan, on which an enrollee is entitled to receive covered services from the enrollee's respective participating managed health care system.

(7) "Enrollee" means a person who meets all eligibility requirements, who is enrolled in the plan, and for whom applicable premium payments have been made.

(8) "Family" means an individual or an individual and the individual's spouse, if not legally separated, and the individual's dependent children. For purposes of eligibility determination and enrollment in the plan, an individual cannot be a member of more than one family.

(9) "Family dependent" means a subscriber's legal spouse, if not legally separated, or the subscriber's dependent child, who meets all eligibility requirements, is enrolled in the plan, and for whom the applicable premium has been paid.

(10) "Grievance procedure" means the formal process for resolution of problems or concerns raised by enrollees which cannot be resolved in an informal manner to the enrollee's satisfaction. "Grievance" means a problem or concern presented for resolution through a grievance procedure.

(11) "Gross family income" means the total income of all members of an enrollee's family, regardless of whether those family members enroll in the plan. (a) For purposes of this definition, for applications for enrollment which are received by the plan on or before March 31, 1989, "income" includes but is not limited to wages and salaries, net income from rentals or self-employment, tips, interest income, dividends, royalties, public or private pensions, and Social Security benefits. (b) For purposes of this definition, for applications for enrollment which are received by the plan on or after April 1, 1989 and for premium payments which are made for coverage on or after June 1, 1989, "income" means total cash receipts before taxes from all sources, with the exceptions noted below. (i) Income includes money wages and salaries before any deductions; net receipts from nonfarm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses); net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses); regular payments from Social Security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including aid to families with dependent children, supplemental security income, emergency assistance money payments, and nonfederally-funded general assistance or general relief money payments), and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions

(including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships and assistantships, if received as or convertible by the recipient into cash; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings. (ii) Income does not include the following types of money received: Capital gains; any assets drawn down as withdrawals from a bank, the sale of property, a house or a car; tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury (except workers' compensation). Also excluded are noncash benefits, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, and such federal noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance. (c) "Income" shall not include income earned by dependent children, nor shall it include income of a family member who resides in another household when such income is not available to those family members seeking enrollment in the plan. (d) In the event that an item of income is received periodically, but less frequently than once per month, the latest amount received will be divided by the number of months in the period (i.e., between payments) in order to calculate an average amount per month. That monthly average will be combined with other monthly items of income to derive a monthly total, which will be used in the calculation of income as a percentage of federal poverty level. (For example, if an applicant receives quarterly interest payments in January, April, July, and October, and applies for coverage by the plan in September, the July payment will be divided by three to obtain a monthly income amount.)

(12) "Managed health care system" (or "MHCS") means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

(13) "Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

(14) "Open enrollment" means a time period designated by the administrator during which enrollees may apply to transfer their membership from one participating managed health care system to another. There shall be at least one open enrollment period of at least twenty consecutive days, at least once annually, in each site served by the plan.

(15) "Participating," when referring to a managed health care system, means one that has entered into a contract with the plan to provide covered services to enrollees. When referring to a health care provider, "participating" means one who is employed by or has entered into a contract with a participating managed health care system to provide covered services to enrollees.

(16) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which a subscriber makes to the plan on behalf of the subscriber and family dependents in consideration for enrollment in the plan.

(17) "Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

(18) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of enrollees in the plan and in that MHCS.

(19) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which enrollees shall be entitled to receive from participating managed health care systems.

(20) "Service area" means the geographic area served by a participating managed health care system as defined in its contract with the plan.

(21) "Site" means a geographic area designated by the plan in which one or more participating managed health care systems are offered to enrollees for selection.

(22) "Subscriber" means an enrollee, or the parent or legal guardian of an enrolled dependent child, who has been designated by the plan as the individual to whom the plan and the managed health care system will issue all notices, information requests and premium bills on behalf of all enrolled family members. For purposes of chapter 55-01 WAC, notice to a subscriber shall be considered notice to all enrolled members of the subscriber's family as well.

(23) "Subsidy" means the difference between the rate paid by the administrator to a managed health care system on behalf of an enrollee and the enrollee's premium responsibility.

(24) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health care services, administered by the plan administrator through participating managed health care systems, created by chapter 70.47 RCW.

[Statutory Authority: RCW 70.47.050. 92-14-088, § 55-01-010, filed 6/30/92, effective 7/31/92; 89-11-059 (Order 89-002), § 55-01-010, filed 5/17/89; 89-06-001 (Order 89-001), § 55-01-010, filed 2/16/89; 88-24-030 (Order 88-001), § 55-01-010, filed 12/2/88.]

WAC 55-01-020 Schedule of benefits. (1) The administrator shall design and from time to time may revise a schedule of benefits which shall include such physician services, inpatient and outpatient hospital services, proven preventive and primary care services, all services necessary for prenatal, postnatal and well-child care, and other services as determined by the administrator to be necessary for basic health care and which enrollees shall receive in return for premium payments to the plan and payment of required copayments. However, for the period beginning July 1, 1992, and ending June 30, 1993, the schedule of benefits shall not include prenatal or postnatal services for enrollees who are eligible for coverage under the medical assistance program under chapter 74.09 RCW, except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider, or except to provide any such services associated with pregnancies diagnosed by the managed care provider before July 1, 1992. The schedule of benefits may include copayments, limitations and exclusions which the administrator determines are

appropriate and consistent with the goals and objectives of the plan.

(2) In designing and revising the schedule of benefits, the administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary basic health care services, as well as the cost to the enrollees and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

(3) Prior to enrolling in the plan, each applicant will be given a complete written description of covered benefits, including all copayments, limitations and exclusions. Enrollees will also be given information on the services, providers, facilities, hours of operation, and other information descriptive of the managed health care system(s) available to enrollees in a given site.

(4) Subscribers will be given written notice by the plan of any planned revisions to the benefit package and the accompanying premiums, such notice to be mailed at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first class postage paid, directed to the enrollee at the enrollee's last mailing address on file with the plan. The administrator will make available a separate schedule of benefits for children, eighteen years of age and younger, for those who choose to enroll only their dependent children in the plan.

[Statutory Authority: RCW 70.47.050. 92-14-097, § 55-01-020, filed 6/30/92, effective 7/31/92; 88-24-030 (Order 88-001), § 55-01-020, filed 12/2/88.]

WAC 55-01-030 Premiums and copayments. (1) Each subscriber shall be responsible for paying a monthly premium to the plan, on behalf of the subscriber and all family dependents, according to a premium schedule to be provided by the plan at the time the subscriber is enrolled by the plan. The amount of premium payable by any subscriber will be based upon the subscriber's gross family income and rates payable to participating managed health care systems, and may vary with the number and ages of individuals enrolled from a given family. A third party may, with the approval of the administrator and through a mechanism acceptable to the administrator, pay the premium on behalf of any enrollee. Premium amounts payable shall be a monthly dollar payment or a percentage of the total rate payable by the plan. A statement of the monthly amount due will be mailed to the subscriber upon determination of eligibility for the plan.

(2) Based on the information provided by an enrollee on the application for enrollment, and any other information obtained by the plan, the enrollee will be informed of the premium amount due. The plan will notify subscribers in writing of any revisions to the premium schedule or to the premium amounts payable to the plan, such notice to be mailed at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect, except that retroactive enrollment of a newborn or newly adopted child (as provided in WAC 55-01-050(6)) may result in a corresponding retroactive increase in premium payable to the plan. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first class postage paid, directed to the enrollee at the enrollee's last mailing address on file with the plan.

(3) Once the plan has determined that a subscriber and members of the subscriber's family (if any) are eligible for enrollment, the plan will bill the subscriber for the family's first month's premium. The subscriber and family members will not be eligible to receive covered services on the effective date of enrollment specified by the plan unless the premium bill is paid in full by the due date specified on the bill. Thereafter, the plan will bill each subscriber monthly, and the subscriber shall be responsible for payment of the billed amount in full by the date specified on the bill.

(4) Premium bills must be paid in full by the date specified on the bill. Payment may be made in person at the plan's administrative office in Olympia, Washington, or by mail to the address specified on the bill. If the plan does not receive payment in full of a premium bill by 5:00 p.m. on the date specified on the bill, the plan shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with the plan, requiring payment in full by a date not less than ten days from the date of the notice. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be disenrolled effective the first day of the month following the last month for which full premium payment was received by the plan. Partial payment of premiums due will be regarded as nonpayment. The plan may disenroll a subscriber and enrolled family members in the event that the subscriber receives more than two delinquency notices in a twelve-month period.

(5) Enrollees shall be responsible for paying any required copayment directly to the provider of a covered service, unless the enrollee has been instructed by his or her managed health care system or the plan to make payment to another party. Copayments must be paid in full by the enrollee at the time of service. Failure to pay a required copayment in full at the time of service may result in the denial or rescheduling of that service by the managed health care system. Repeated failure to pay copayments in full on a timely basis may result in disenrollment, as provided in WAC 55-01-060(2).

[Statutory Authority: RCW 70.47.050. 92-14-088, § 55-01-030, filed 6/30/92, effective 7/31/92; 89-06-001 (Order 89-001), § 55-01-030, filed 2/16/89; 88-24-030 (Order 88-001), § 55-01-030, filed 12/2/88.]

WAC 55-01-040 Eligibility. (1) To be eligible for enrollment in the plan, an individual must:

(a) Be under age sixty-five;

(b) Not be eligible for medicare;

(c) Reside within the service area of a participating managed health care system; and

(d) Have a gross family income at the time of enrollment that does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the Federal Department of Health and Human Services.

Persons not meeting all of these criteria, as evidenced by information submitted on the application for enrollment

or otherwise obtained by the plan, will not be enrolled. An enrollee who subsequently fails to meet all of the criteria will be disenrolled from the plan as provided in WAC 55-01-060—except that an enrollee whose gross family income exceeds twice the federal poverty level may continue as an enrollee for up to six months, provided all other criteria are met and provided that the enrollee pays a monthly premium equal to the rate stated in the contract between the plan and the participating managed health care system selected by the enrollee.

(2) An individual otherwise eligible for enrollment in the plan may be denied enrollment if the administrator has determined that acceptance of additional enrollment in a given service area would exceed limits established by the legislature, would jeopardize the orderly development of the plan in that service area, or would result in an overexpenditure of plan funds. In the event that the administrator closes enrollment in a given service area, the plan will continue to accept applications for enrollment, but will not process those applications for determination of eligibility. The plan will place the names of applicants on a waiting list in the order in which applications are received, and will so notify the applicants. In the event that enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by the plan of the opportunity to enroll; provided that the plan may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, prior to determining their eligibility.

[Statutory Authority: RCW 70.47.050. 88-24-030 (Order 88-001), § 55-01-040, filed 12/2/88.]

WAC 55-01-050 Enrollment in the plan. (1) Any individual applying for enrollment in the plan must complete and submit the plan's application for enrollment. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or legal guardian, who shall also be held responsible by the plan for payment of premiums due on behalf of the child.

(2) Each applicant shall complete and sign the application for enrollment, listing family members to be enrolled and supplying such other information as required by the plan. (a) Documentation will be required, showing the amount and sources of applicants' income for the most recent complete calendar month as of the date of application. Applicants will also be required to submit a copy of their most recent federal income tax form. Income documentation shall be required for all income-earning family members, including those not applying for enrollment, except for family members who reside in another household and whose income is not available to the family seeking enrollment, and dependent children. (b) Documentation of residence shall also be required, displaying the applicant's name and address. (c) The plan may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility or managed health care system selection. (d) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment in the plan. Intentional submission of false information may result in disenrollment of the applicant and all enrolled family members, retroactive to the date upon which coverage began.

(3) Each family applying for enrollment must designate a participating managed health care system from which all enrolled family members will receive covered services. All applicants from the same family must receive covered services from the same managed health care system. No applicant will be enrolled for whom designation of a participating managed health care system has not been made as part of the application for enrollment. The administrator will establish procedures for the selection of managed health care systems, which will include conditions under which an enrollee may change from one managed health care system to another. Such procedures will allow enrollees to change from one managed health care system to another during open enrollment, or otherwise upon showing of good cause for the transfer.

(4) Except as provided in WAC 55-01-040(2), applications for enrollment will be reviewed by the plan within thirty days of receipt and those applicants satisfying the eligibility criteria and who have provided all required information, documentation and premium payments will be notified of their effective date of enrollment.

(5) Eligible applicants will be enrolled in the plan in the order in which their completed applications, including all required documentation, have been received by the plan, provided that the applicant also remits full payment of the first premium bill to the plan by the due date specified by the plan.

(6) Not all family members are required to apply for enrollment in the plan; however, any family member for whom application for enrollment is not made at the same time that other family members apply may not subsequently enroll as a family dependent until the next open enrollment period available to that family member. Eligible newborn and newly adopted children may be enrolled effective from the date of birth or physical placement with the adoptive parents for adoption, provided that application for enrollment is submitted to the plan within sixty days of the date of birth or such placement for adoption. A newly acquired spouse of an enrollee may apply for enrollment within thirty days of the date of marriage and, if found eligible by the plan, will be enrolled on the first of a month following completion of the enrollment process by the plan, provided that the addition of the spouse does not otherwise render the family ineligible for coverage by the plan.

(7) Any enrollee who disenrolls from the plan for reasons other than (a) ineligibility due to an increase in gross family income or (b) coverage by another health care benefits program may not reenroll in the plan for a period of twelve months from the effective date of disenrollment. An enrollee who disenrolls because of ineligibility due to an increase in gross family income may reenroll in the event that gross family income subsequently falls to a level which qualifies the enrollee for eligibility. An enrollee who disenrolls because of coverage by another health care benefits program may reenroll in the event that the enrollee becomes ineligible for such other coverage, provided that the enrollee has been continuously covered since the date of disenrollment from the plan, and provides documentation of such continuous coverage to the plan. Before any person shall be reenrolled in the plan, that person must complete a

new application for enrollment and must be determined by the plan to be otherwise eligible for enrollment as of the date of application.

(8) The plan may require any enrollee or applicant for enrollment in the plan who appears to meet eligibility requirements for medical care under chapter 74.09 RCW to complete the eligibility determination process under chapter 74.09 RCW prior to enrollment or continued participation in the plan.

(9) Once every six months, the plan will request verification of information from enrollees ("recertification"), which may include a request to complete a new application form and submit required documentation. At recertification, enrollees will be required to report their gross family income for the most recent complete calendar month as of the recertification date specified by the plan, and to provide the same documentation of such income as required of applicants. The plan may request information more frequently from an enrollee for the purpose of verifying eligibility if the plan has good cause to believe that the enrollee's income, residence, family size or other eligibility criteria may have changed since the date on which information was last received by the plan. Enrollees shall be given at least twenty days from the date of any such information request to respond to the request. Failure to respond within the time designated in any information request shall result in a second request from the plan. Failure to respond within the time designated in any second request for information may result in disenrollment of the enrollee. Each enrollee is responsible for notifying the plan within thirty days of any changes which could affect the enrollee's eligibility or premium responsibility.

[Statutory Authority: RCW 70.47.050. 92-14-097, § 55-01-050, filed 6/30/92, effective 7/31/92; 89-22-014, § 55-01-050, filed 10/24/89, effective 11/24/89; 89-06-001 (Order 89-001), § 55-01-050, filed 2/16/89; 88-24-030 (Order 88-001), § 55-01-050, filed 12/2/88.]

WAC 55-01-060 Disenrollment from the plan. (1) An enrollee may disenroll effective the first day of any month by giving the plan at least ten days prior written notice of the intention to disenroll. Reenrollment in the plan shall be subject to the provisions of WAC 55-01-050(7). The administrator shall also establish procedures for notice by an enrollee of a disenrollment decision, including the date upon which disenrollment shall become effective. Nonpayment of premium by an enrollee shall be considered an indication of the enrollee's intention to disenroll from the plan.

(2) The plan may disenroll any enrollee from the plan for good cause, which shall include: Failure to meet the eligibility requirements set forth in WAC 55-01-040; loss of eligibility; nonpayment of premium; repeated failure to pay copayments in full on a timely basis; failure to provide eligibility information necessary to determine whether the enrollee may be eligible for medical care under chapter 74.09 RCW within thirty days of the date of request by the plan; failure to apply when such application is required by the plan to the department of social and health services for determination of eligibility for medical care under chapter 74.09 RCW within thirty days of the date of request by the plan; fraud or abuse (including but not limited to serious misconduct); intentional misconduct; and refusal to accept or follow procedures or treatment determined by a participating provider to be essential to the health of the enrollee, where the managed health care system demonstrates to the satisfaction of the plan that no professionally acceptable alternative form of treatment is available from the managed health care system, and the enrollee has been so advised by the managed health care system. The plan shall provide the enrollee with advance written notice of its intent to disenroll the enrollee. Such notice shall specify an effective date of disenrollment, which shall be at least ten days from the date of the notice, and shall describe the procedures for disenrollment, including the enrollee's right to appeal the disenrollment decision as set forth in WAC 55-01-070. Prior to the effective date specified, if the enrollee submits a grievance to the plan contesting the disenrollment decision, as provided in WAC 55-01-070(3), disenrollment shall not become effective until the date, if any, established as a result of the plan's grievance procedure, provided that the enrollee otherwise remains eligible and continues to make all premium payments when due; and further provided that the enrollee does not pose a threat of nonconsensual violent, aggressive or sexually aggressive behavior, assault or battery or purposeful damage to or theft of managed health care system property, or the property of staff or providers, patients or visitors while on the property of the managed health care system or one of its participating providers.

(3) Any applicant for enrollment in the plan who knowingly provides false information to the plan or to a participating managed health care system may be disenrolled by the plan and may be held financially responsible for any covered services obtained from the plan. The administrator may apply other available remedies as well.

[Statutory Authority: RCW 70.47.050. 92-14-097, § 55-01-060, filed 6/30/92, effective 7/31/92; 89-06-001 (Order 89-001), § 55-01-060, filed 2/16/89; 88-24-030 (Order 88-001), § 55-01-060, filed 12/2/88.]

WAC 55-01-070 Hearings and grievances. The plan will develop procedures for the expeditious resolution of enrollees' grievances, and will require participating managed health care systems to do the same.

(1) If an enrollee has a grievance pertaining to a managed health care system, the enrollee shall exhaust the managed health care system's grievance procedure prior to requesting consideration of the grievance by the plan. The managed health care system's grievance procedure shall provide for expeditious resolution by managed health care system personnel with authority to require corrective action. There shall be a written reply from the managed health care system stating either the decision and its basis, or the reasons for failure to reach a decision, within thirty days of receipt of the written grievance. An enrollee has the right to request consideration of the grievance by the administrator if the final decision is adverse or if the written reply is not received within thirty days from the date the managed health care system received the written grievance.

(2) If an enrollee has a grievance pertaining to actions of the plan, the enrollee may submit the grievance to the plan for resolution by the plan's grievance procedure. A written description of the plan's grievance procedure will be provided to the enrollee upon enrollment, or at any time upon request. The plan's grievance procedure shall provide

for resolution of the grievance within thirty days of receipt of complete information describing the grievance and its basis.

(3) An enrollee who is involuntarily disenrolled by the plan may contest the disenrollment by submitting a grievance to the plan, within ten days of the notice of disenrollment, for resolution by the plan's grievance procedure. The plan shall issue and mail a written decision within thirty days of receiving the grievance.

(4) An individual whose application for enrollment in the plan is denied may contest the denial of enrollment by submitting a grievance to the plan, within ten days of the notice by the plan of such denial, for resolution by the plan's grievance procedure. The plan shall issue and mail a written decision within thirty days of receiving the grievance.

(5) If the plan's decision resulting from its grievance procedure is adverse to an enrollee or applicant, he or she may, within fifteen days of receiving notice of the grievance decision, request a hearing under chapters 34.04 and 34.12 RCW in order to contest the plan's decision.

[Statutory Authority: RCW 70.47.050. 88-24-030 (Order 88-001), § 55-01-070, filed 12/2/88.]

WAC 55-01-080 Contracts with managed health care systems. (1) The administrator may enter into a contract with any managed health care system which, in the opinion of the administrator, qualifies for participation in the plan. The administrator shall establish, and may from time to time revise, minimum standards to be satisfied by participating managed health care systems.

(2) No managed health care system may participate in the plan without entering into a written contract with the plan.

(3) The administrator shall develop procedures for the resolution of disputes between the plan and a managed health care system which will be set forth in the contract between the plan and the managed health care system.

[Statutory Authority: RCW 70.47.050. 88-24-030 (Order 88-001), § 55-01-080, filed 12/2/88.]