# ANALYST CHECKLIST

## **DISABILITY CARRIER – GROUP SHORT TERM PLANS**

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| Issuer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SERFF Tracker ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Network Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sub-networks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider Network Type (Single or Tiered\*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Network Line of Business (dental, medical, medical and vision, vision):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*** TIERED as described in [WAC 284-170-330](http://apps.leg.wa.gov/wac/default.aspx?cite=284-170-330)

**GENERAL REVIEW REQUIREMENTS**

Authority to Review Contract – RCW 48.18.100

Prior Approval Required – [RCW 48.43.005(26)(l)](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.005)

[WAC 284-43-8020](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-8020)

| **Topic** | **Sub-Topic** | **Reference** | **Specific Issue** | **Form and page**  **or section** | **Additional Information / Comments** |
| --- | --- | --- | --- | --- | --- |
| **Alternative to Hospitalization**  **Alternative to Hospitalization**  **(Cont’d)** | Requirement  to cover home care in lieu of hospitalization  Requirement to cover home care in Lieu of Hospitalization (Cont’d) | WAC 284-96-500(1) | As an alternative to hospitalization or institutionalization and with the intent to cover placement of the enrollee in the most appropriate, cost-effective setting, plan must include substitution of home health care in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter [70.127](http://app.leg.wa.gov/RCW/default.aspx?cite=70.127) RCW, at equal or lesser cost. |  |  |
| WAC 284-96-500(2) | * Such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments. |  |  |
| WAC 284-96-500(3) | * Such substitution must be made only with the consent of the insured and on the recommendation of the insured's attending physician or licensed provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual enrollee. |  |  |
| WAC 284-96-500(4) | * May require that home health agencies or similar alternative care providers have written treatment plans which are approved by the enrollee’s attending physician or other licensed provider. |  |  |
| WAC 284-96-500(5) | * Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's contract. |  |  |
|  |  |  |  |  |  |
| **Congenital Anomolies** | Requirement for Coverage | RCW 48.21.155(1) | If plan provides coverage for dependent children of the enrollee, must provide coverage for newborn infants of the enrollee from and after the moment of birth. Coverage must include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth. |  |  |
|  |  |  |  |  |  |
| **Contract Standards Required**  **Contract Standards Required (Cont’d)**  **Contract Standards Required (Cont’d)**  **Contract Standards Required (Cont’d)**  **Contract Standards Required (Cont’d)**  **Contract Standards Required (Cont’d)** | Rate and Form Filing Instructions | WAC 284-58-030(3) | Filing must be complete and comply with The SERFF Industry Manual, and Washington State SERFF Health and Disability Form Filing General Instructions. |  |  |
|  | RCW 48.18.110(1)(c) | * The filing must not:   + contain any inconsistent, ambiguous, misleading clauses, exceptions, or conditions, which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract; |  |  |
| RCW 48.18.110(1)(d) | * + have any title, heading, or other indication of its provisions which is misleading; |  |  |
| RCW 48.18.110(2) | * Benefits provided must be reasonable in relation to the premium charged. |  |  |
| RCW 48.18.190 | * Policy must contain entire contract. |  |  |
| WAC 284-58-030(2) | * All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type. |  |  |
|  | RCW 48.21.060 | * Contract must include a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued; that all statements made by the policyholder or by the individuals insured shall in the absence of fraud be deemed representations and not warranties, and that no statement made by any individual insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such individual or to his or her beneficiary, if any. |  |  |
| Cancellation | WAC 284-43-8030(3) | A short-term limited duration medical plan cannot be canceled by the carrier during the coverage period except for the following: |  |  |
|  | WAC 284-43-8030(3)(a) | * Nonpayment of premium; |  |  |
|  | WAC 284-43-8030(3)(b) | * Violation of published policies of the carrier approved by the insurance commissioner |  |  |
|  | WAC 284-43-8030(3)(c) | * A member's committing fraudulent acts as to the carrier; |  |  |
|  | WAC 284-43-8030(3)(d) | * A member's material breach of the medical plan; or |  |  |
|  | WAC 284-43-8030(3)(e) | * Change or implementation of federal or state laws that no longer permit the continued offering of the coverage. |  |  |
| Rescission | WAC 284-43-8030(2) | A short-term limited duration medical plan cannot be rescinded by the carrier during the coverage period except for a member's committing fraudulent acts as to the carrier or a member's intentional nondisclosure regarding his or her coverage under a short-term limited duration medical plan during the twelve-month period prior to the date of application. If the plan is rescinded, the carrier must refund to the member all payments made by or on behalf of the member prior to the rescission date or the expiration date of the short-term limited duration medical plan. |  |  |
| Reason for Cancellation or Recission  Reason for Cancellation or Recission (Cont’d) | WAC 284-43-8030(7)(b) | When cancellation or rescission is for any other reason allowed under this section, other than nonpayment of premium, the carrier must notify the member in writing twenty days prior to the cancellation or rescission date or the expiration date of the short-term limited duration medical plan, whichever occurs first. A carrier may provide notice less than twenty days prior to the cancellation or rescission date only if the remaining duration of the short-term limited duration medical plan would make it impossible for the carrier to provide notice twenty days prior to the cancellation or rescission date. In such case, notice must be provided no later than ten days prior to the cancellation or rescission date or the expiration date of the short-term limited duration medical plan, whichever occurs first. The notice must specifically state the reason(s) for the cancellation or rescission. |  |  |
| WAC 284-43-8030(7)(c) | * The notice must be phrased in simple language that is readily understood |  |  |
| Claim forms,  Proof of Loss and Time of payment of claims | RCW 48.21.050 | No policy shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the individuals insured than would be permitted by the standard provisions required for individual disability insurance policies: |  |  |
| Payment of benefits | RCW 48.21.110 | Contract cannot conflict with the following:   * The benefits payable under any group insurance policy must be payable to the employee or other insured member of the group or to the beneficiary designated by him or her, other than the policyholder, employer or the association or any officer thereof as such, subject to provisions of the policy in the event there is no designated beneficiary as to all or any part of any sum payable at the death of the individual insured. |  |  |
|  |  | * The policy may provide that any hospital, medical, or surgical benefits thereunder may be made payable jointly to the insured employee or member and the person furnishing such hospital, medical, or surgical services. |  |  |
| Physical examination and autopsy | RCW 48.21.100 | Contract may provide that the insurer has the right and opportunity to examine the person of the individual insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law. |  |  |
| Right to legal or arbitration proceedings | Firestone v. Bruch | In the case of controversy arising out of the contract, a subscriber must not be denied the right to have the controversy determined by legal or arbitration proceedings. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) |  |  |
| No unreasonable payment delays | WAC 284-30-380(4);  Thiringer v. American Motors Ins | • If plan includes a subrogation provision, the provision must clearly notify enrollee of their right to be fully compensated.  • Contract must not contain any provision that unreasonably restricts or delays the payment of benefits payable under the contract. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party. |  |  |
|  | WAC 284-43-8030(7)(a) | When cancellation is for nonpayment of premium, the carrier must notify the member in writing ten days prior to the cancellation date that his or her short-term limited duration medical plan will be canceled, unless payment is made prior to the cancellation date. |  |  |
|  | WAC 284-43-8030(7)(c) | * The notice must be phrased in simple language that is readily understood |  |  |
|  | RCW 48.21.325 | * When an authorized plan representative approves a claim for an individual prescription, the plan may not later reject that claim. |  |  |
| Discretionary Clauses Prohibited  Discretionary Clauses Prohibited  (Cont’d) | RCW 48.18.110(1)(c) | * Plan may not contain any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract. |  |  |
| WAC 284-96-012(1) | * Plan may not contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to an insurer, its agents, officers, employees, or designees in interpreting the terms of a policy or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results: |  |  |
| WAC 284-96-012(1)(a) | * + That the insurer's interpretation of the terms of the policy is binding; |  |  |
| WAC 284-96-012(1)(b) | * + That the insurer's decision regarding eligibility or continued receipt of benefits is binding; |  |  |
| WAC 284-96-012(1)(c) | * + That the insurer's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding; |  |  |
| WAC 284-96-012(1)(d) | * + That there is no appeal or judicial remedy from a denial of a claim; |  |  |
| WAC 284-96-012(1)(e) | * + That deference must be given to the insurer's interpretation of the contract or claim decision; and |  |  |
| WAC 284-96-012(1)(f) | * + That the standard of review of an insurer's interpretation of the policy or claim decision is other than a de novo review. |  |  |
| WAC 284-96-012(2) | * Nothing prohibits an insurer from including a provision in a policy that informs an insured that as part of its routine operations the insurer applies the terms of its policies for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes. |  |  |
|  | WAC 284-43-8000(4) | A carrier must not issue a short-term limited duration medical plan during an annual open enrollment period, as defined in WAC [284-43-1080](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-1080), for coverage beginning in the upcoming year. |  |  |
| Less than 3-month Maximum Duration | WAC 284-43-8000(5)(a) | The duration of a short-term limited duration medical plan cannot exceed three months |  |  |
| Renewal, Continuation, or Nonrenewal Provisions | WAC 284-43-8000(5)(b) | A short-term limited duration medical plan cannot be renewed or extended, except: |  |  |
| WAC 284-43-8000  (1)(a)(ii)(C) | * An extension of the medical plan term while hospitalized. If a member is hospitalized as an inpatient on the expiration date of the medical plan, the member's coverage under the medical plan will continue for purposes of that covered medical condition without payment of additional premium. The coverage will continue until the date the member is discharged from the hospital or until the date on which the applicable benefit maximums are reached, whichever occurs first. |  |  |
| WAC 284-43-8000(5)(c) | * A short-term limited duration medical plan cannot be issued if it would result in a person being covered by a short-term limited duration medical plan for more than three months in any twelve-month period. |  |  |
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| **Coordination of Benefits**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)**  **Coordination of Benefits**  **(Cont’d)** | Disclosure of Coordination |  | **Please note which COB Model is used and proceed to the required COB elements.** | **Model A** | **Model B** |
| WAC 284-51-200 | Each certificate of coverage under a contract that provides for COB must contain a description of the COB provisions. |  |  |
|  | * Does the contract use the model COB provisions in WAC 284-51-255 Appendix A? **OR** |  |  |
|  | * Does the contract use the model “plain language description” of COB in WAC 284-51-260, Appendix B? |  |  |
| General  General  (Cont’d) | WAC  284-51-200(3) | • Plan need not use the specific words and format provided in WAC 284-51-255 and the plain language explanation in WAC 284-51-260. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred, and that indemnify, provided they do not conflict with the requirements of Chapter 284-51 WAC. |  |  |
| WAC  284-51-200  (4)(a) | * Plan cannot have a COB provision that permits it to reduce its benefits on the basis that:   o Another plan exists and the enrollee did not enroll in that plan; |  |  |
| (4)(b) | o A person could have been covered under another plan; or |  |  |
| (4)(c) | o A person could have elected an option under another plan that pays a higher level of benefits than what he elected. |  |  |
| WAC 284-51-200(5) | • Plan may not provide that its benefits are "always excess" or "always secondary" except as permitted in Chapter 284-51 WAC. |  |  |
| RCW 48.21.200(1) | • A carrier may not administer COB in a way that reduces total benefits payable below an amount equal to 100% of total allowable expenses. |  |  |
| WAC  284-51-230(1) | • Any secondary plan must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. |  |  |
|  | * The secondary plan is not required to pay an amount in excess of its maximum benefit plus accrued savings. |  |  |
|  | * The plan must provide that the enrollee is not responsible for a deductible amount greater than the highest of the two deductibles. |  |  |
| WAC  284-51-195(1) | • When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense. |  |  |
| Time Limit | WAC  284-51-215(1) | Plan must not unreasonably delay payment of a claim due to a COB provision. Any time limit in excess of 30 days is unreasonable. |  |  |
| Definition of “Plan” for purposes of COB  Definition of “Plan” for purposes of COB  (Cont’d) | WAC  284-51-195(12) | * "Plan" means coverage with which coordination is allowed. Separate parts of a plan provided through alternative contracts intended to be part of a coordinated package of benefits are considered one plan. There is no COB among the separate parts of the plan. |  |  |
| WAC  284-51-195(12)(a) | * If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying COB. |  |  |
| WAC  284-51-195(12)(a) | * Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in WAC 284-51-195(12). |  |  |
| WAC 284-51-195(12)(b)(i) | * "Plan" includes:   + Group or individual contracts or blanket disability contracts; |  |  |
| WAC 284-51-195(12)(b)(ii) | * + Closed panel plans or other forms of group or individual coverage; |  |  |
| WAC 284-51-195(12)(b)(iii) | * + The medical care components of long-term care contracts, such as skilled nursing care; and |  |  |
| WAC 284-51-195(12)(b)(iv) | * + Medicare or other governmental benefits, as permitted by law. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. |  |  |
| WAC 284-51-195(12)(c)(i) | * “Plan” does not include:   + Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage; |  |  |
| (ii) | * + Accident only coverage; |  |  |
| (iii) | * + Specified disease or specified accident coverage; |  |  |
| (iv) | * + Limited benefit health coverage, as defined in WAC 284-50-370; |  |  |
| (v) | * + School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; |  |  |
| (vi) | * + Benefits provided in long-term care insurance policies for nonmedical services, e.g., personal care, adult day care, homemaker services, assistance with ADLs, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; |  |  |
| (vii) | * + Medicare supplement policies; |  |  |
| (viii) | * + A state plan under Medicaid; |  |  |
| (ix) | * + A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; |  |  |
| (x) | * + Automobile insurance policies required by statute to provide medical benefits; |  |  |
| (xi) | * + Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined at section 3, chapter 267, Laws of 2007. |  |  |
| Contract Description of COB | WAC  284-51-200(7) | * If a person has met the requirements for coverage under the primary plan, a closed panel plan in secondary position must pay benefits as if the covered person had met the requirements of the closed panel plan. COB may occur during the claim determination period even where there are no savings in the closed panel plan. |  |  |
|  | WAC  284-51-195(5) | * "Closed panel plan" means a plan that provides benefits in the form of services primarily through providers employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member. |  |  |
|  | WAC 284-51-195(1) | * The definition of “allowable expense” should be clear that when coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the allowable expense the secondary plan would have paid if it was primary. A secondary plan must not be required to pay an amount in excess of its maximum benefit plus accrued savings. |  |  |
| Rules for Coordination of Benefits  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d) | WAC  284-51-205(1)(a); WAC 284-51-205(3) | Contract may not contain any provisions that are inconsistent with or less favorable than these COB rules: |  |  |
| * The primary plan must provide benefits as if the secondary plan did not exist. A plan may only take into consideration benefits provided by another plan when it is secondary to that other plan. |  |  |
| WAC  284-51-205 (1)(b) | * If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must provide benefits as if it were primary when an enrollee uses a nonpanel provider, except for emergency services or authorized referrals provided by the primary plan. |  |  |
| WAC  284-51-205 (1)(c) | * When multiple contracts providing coordinated coverage are treated as a single plan per WAC 284-51-195, the COB rules apply only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the plan, the issuer designated as primary within the plan is responsible for the plan's compliance with Chapter 284-51 WAC. |  |  |
| WAC  284-51-205 (1)(d) | * If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans pay. Each secondary plan must consider the benefits of the primary plan and the benefits of any other plan, which, under the COB rules, has its benefits determined before those of that secondary plan. |  |  |
| WAC  284-51-205 (2)(a) | * Except as provided below, a plan that contains noncompliant COB provisions is always the primary plan unless the provisions of both plans state that the complying plan is primary. |  |  |
| WAC  284-51-245 (2)(a) | * + A plan with order of benefit determination rules that comply with the WAC rules (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary", or that uses order of benefit determination rules inconsistent with the WAC rules (noncomplying plan) on the following basis: |  |  |
| (2)(a)(i) | * + - If the complying plan is the primary plan, it must provide its benefits first; |  |  |
| (2)(a)(ii) | * + - If the complying plan is the secondary plan under Chapter 284-51 WAC, it must provide its benefits first, but the amount of benefits payable must be determined as if the complying plan were the secondary plan. In this situation, the payment is the limit of the complying plan's liability; and |  |  |
| WAC  284-51-245 (2)(a)(iii) | * If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within forty-five days after the date on the letter making the request, the complying plan may assume the benefits of the noncomplying plan are identical to its own, and pay its benefits accordingly. If, within twenty-four months after payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it must adjust payments accordingly between the plans. |  |  |
| WAC  284-51-245 (2)(b) | * + - If the noncomplying plan reduces its benefits so the enrollee receives less in benefits than they would have received had the complying plan provided its benefits as the secondary plan and the noncomplying plan provided its benefits as the primary plan, and governing state law allows the right of subrogation outlined below, then the complying plan may advance to the covered person or on behalf of the covered person an amount equal to the difference. |  |  |
| WAC  284-51-245 (2)(c) | * + - Complying plan may not advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense. In consideration of the advance, the complying plan is subrogated to all rights of the enrollee against the noncomplying plan. The advance by the complying plan must be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation. |  |  |
| WAC  284-51-205 (2)(b) | * Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. (e.g., major medical coverages superimposed over base plan hospital and surgical benefits, and insurance coverages written in connection with a closed panel plan to provide out-of-network benefits.) |  |  |
| WAC 284-51-205(4) | * **Order of benefit determination.** Each plan determines its order of benefits using the first of the following rules that applies: |  |  |
| WAC  284-51-205 (4)(a)(i) | * + Nondependent or dependent.     - Subject to the following, the plan that covers the person other than as a dependent (e.g., as an employee, member, subscriber, policyholder or retiree) is the primary plan and the plan that covers the person as a dependent is the secondary plan. |  |  |
| WAC  284-51-205 (4)(a)(ii)(A) | * + - If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is: |  |  |
| WAC  284-51-205 (4)(a)(ii)(A)(I) | * + - * Secondary to the plan covering the person as a dependent; and |  |  |
| WAC  284-51-205 (4)(a)(ii)  (A)(II) | * + - * Primary to the plan covering the person as other than a dependent (e.g., a retired employee); |  |  |
| WAC 284-51-205 (4)(a)(ii)(B) | * + - * Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan. |  |  |
| WAC  284-51-205(4)(b) | * + Dependent child covered under more than one plan.     - Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits as follows: |  |  |
| 284-51-205(4)(b)(i) | * + - For a dependent child whose parents are married or are living together, whether or not they have ever been married: |  |  |
| 284-51-205 (4)(b)(i)(A) | * + - * The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or |  |  |
| 284-51-205 (4)(b)(i)(B) | * + - * If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. |  |  |
| WAC  284-51-205 (4)(b)(ii) | * + - For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married: |  |  |
| WAC  284-51-205 (4)(b)(ii)(A) | * + - * If a court decree states that one parent is responsible for the dependent child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision; |  |  |
| WAC  284-51-205 (4)(b)(ii)(B) | * + - * If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary; |  |  |
| WAC  284-51-205 (4)(b)(ii)(C) | * + - * If a court decree states that both parents are responsible for the dependent child's health care expenses or coverage, the provisions above for parents married or living together determine the order of benefits; |  |  |
| WAC  284-51-205 (4)(b)(ii)(D) | * + - * If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the dependent child, the above provisions for parents married or living together determine the order of benefits; or |  |  |
| WAC 284-51-205 (4)(b)(ii)(E) | * + - * If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows: |  |  |
| (4)(b)(ii)(E)(I) | * + - * + The plan covering the custodial parent, first; |  |  |
| (4)(b)(ii)(E)(II) | * + - * + The plan covering the custodial parent's spouse, second; |  |  |
| (4)(b)(ii)(E)(III) | * + The plan covering the noncustodial parent, third; and then |  |  |
| (4)(b)(ii)(E)(IV) | * + - * + The plan covering the noncustodial parent's spouse, last. |  |  |
| WAC  284-51-205(4)(b)(iii) | * + - For a dependent child covered under more than one plan of individuals who are not the child’s parents, the order of benefits is determined as if they were the parents of the child. |  |  |
|  | * + Active employee or retired or laid-off employee. |  |  |
| WAC  284-51-205(4)(c)(i) | * The plan that covers a person as an active employee (neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. |  |  |
| WAC 284-51-205(4)(c)(ii) | * If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. |  |  |
| WAC 284-51-205(4)(c)(iii) | * This provision also does not apply if the above provisions regarding nondependents and dependents can determine the order of benefits. |  |  |
|  | * COBRA or state continuation coverage |  |  |
| WAC  284-51-205(4)(d)(i) | * + If a person has coverage provided under COBRA or under a right of continuation under state or federal law, and is covered under another plan, the plan covering him as an employee, member, subscriber or retiree or covering him as a dependent of one of these, is the primary plan and the plan covering that same person under COBRA or under a right of continuation according to state or other federal law is the secondary plan. |  |  |
| WAC 284-51-205(4)(d)(ii) | * + If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply. |  |  |
| WAC  284-51-205(4)(d)(iii) | * + This provision also does not apply if the above provisions regarding nondependents and dependents in (a) of this subsection can determine the order of benefits. |  |  |
|  | |  | | --- | | * Longer or shorter length of coverage | |  |  |
| WAC  284-51-205(4)(e)(i) | * + If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan. |  |  |
| WAC 284-51-205(4)(e)(ii) | * + - To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the enrollee was eligible under the second plan within twenty-four hours after coverage under the first plan ended. |  |  |
|  | * + The start of a new plan does not include: |  |  |
| (4)(e)(iii)(A) | * + - A change in the amount or scope of a plan's benefits; |  |  |
| (4)(e)(iii)(B) | * + - A change in the entity that pays, provides or administers the plan's benefits; or |  |  |
| (4)(e)(iii)(C) | * + - A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan. |  |  |
| WAC 284-51-205(4)(e)(iv) | * + The length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date to determine the length of time his coverage under the present plan has been in force. |  |  |
| WAC  284-51-205(4)(f) | * + If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans. |  |  |
| WAC 284-51-230(3) | * “Gatekeeper requirements” means any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. (e.g, use of network providers, prior authorization, primary care physician referrals, or other similar case management requirements.) If a plan by its terms contains gatekeeper requirements, AND a person fails to comply with such requirements, And an alternative procedure is not agreed upon between both plans and the covered person: |  |  |
| WAC  284-51-230(2)(a) | * + - * If the plan is secondary, all secondary gatekeeper requirements will be waived if the gatekeeper requirements of the primary plan have been met. |  |  |
| WAC  284-51-230(2)(b) | * + - * If the primary plan becomes secondary during a course of treatment, the new primary plan must make reasonable provision for continuity of care if one or more treating providers are not in the new primary plan's network. |  |  |
| WAC  284-51-230(4) | * + - When a plan is secondary, it may reduce its benefits so the total benefits provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate and record its savings from the amount it would have paid had it been primary, and must use these savings to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period, so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period. |  |  |
| Required Provisions |  | If the plan provides for COB, it must contain provisions substantially as follows: |  |  |
| “Facility of Payment” | WAC 284-51-220 | * + - **SKIP IF USING MODEL A LANGUAGE IN THE PLAN.** "If payments that should have been made under this plan are made by another plan, the issuer has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. To the extent of such payments, the issuer is fully discharged from liability under this plan." |  |  |
| “Right of Recovery” | WAC 284-51-225 | * + - **SKIP IF USING MODEL A LANGUAGE IN THE PLAN.** "The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person, other issuer or plan that has received payment.” |  |  |
| “Notice to Covered Persons” | WAC 284-51-235 | * + - The plan must include the following statement in the enrollee contract or booklet provided to covered persons:   "If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.  CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.  To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage." |  |  |
| If Plans Cannot Agree Which is Primary | WAC 284-51-245(4) | If the plans cannot agree on the order of benefits within thirty calendar days after they have received the information needed to pay the claim, they must immediately pay the claim in equal shares and determine their relative liabilities following payment. No plan is required to pay more than it would have paid had it been the primary plan. |  |  |
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| **Dependent Enrollment Requirements**  **Dependent Enrollment Requirements**  **(Cont’d)** | Adoptive Child | RCW 48.01.180(1) | * A child must be considered a dependent child for coverage purposes upon assumption of a legal obligation for total or partial support of a child in anticipation of adoption. On termination of such legal obligations, the child shall no longer be considered a dependent child for coverage purposes. |  |  |
| RCW 48.01.180(2) | * Coverage for dependent children placed for adoption must be provided under the same terms and conditions as apply to natural, dependent children, whether or not the adoption has become final. |  |  |
|  |  |
| RCW 48.01.180(3) | * Contract may not restrict coverage of any dependent child adopted by, or placed for adoption with, an enrollee solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the enrollee is eligible for coverage under the plan. |  |  |
| RCW 48.21.280(2) | * If payment of an additional premium is required to provide coverage for the child, the contract may require notification of placement and payment of the required premium. The notification period shall be no less than sixty days from the date of placement. |  |  |
| Disabled Child Over Age Limit | RCW 48.21.150 | If the contract states that coverage of a dependent child will terminate upon attainment of the limiting age for dependent children, the contract must also state that coverage of a dependent child will not be terminated while the child is and continues to be **both** (1) incapable of self-sustaining employment by reason of developmental or physical disability and (2) chiefly dependent upon the subscriber for support and maintenance.  Issuer may require proof of incapacity and dependency within thirty-one days of the child's attainment of the limiting age and subsequently, but not more than annually after the first two years following attainment of the limiting age. |  |  |
| Newborn Child Enrollment | RCW 48.21.155(1) | * If plan covers dependent children of the enrollee, it must provide coverage for newborn infants of the enrollee from and after the moment of birth. Must include coverage for congenital anomalies of such infant children from the moment of birth. |  |  |
|  | RCW 48.21.155(2) | * If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer. The notification period shall be no less than sixty days from the date of birth. |  |  |
| Dependents Under Age 26 | RCW 48.21.157 | Plans that cover dependents must have language allowing the member to cover dependents under the age of 26. |  |  |
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| **Diabetes** | Coverage Requirements | RCW 48.21.143 (2)(a) | * If the contract provides Pharmacy Benefits, Contract must provide appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, for all subscribers diagnosed “Insulin using”, “Non-insulin using”, and “elevated blood glucose induced by pregnancy. This must include: |  |  |
|  | * + insulin, syringes, injection aids, blood glucose monitors, test strips (for blood glucose monitors, visual blood sugar reading, and urine testing); insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits. |  |  |
| RCW  48.21.143  (2)(b) | * Whether or not the contract provides Pharmacy Benefits, contract must provide:   + outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by providers with expertise in diabetes. |  |  |
|  | * + Issuer may restrict patients to seeing only health care providers who have signed participating provider agreements with the Issuer or an insuring entity under contract with the health care services contractor. |  |  |
| RCW  48.21.143(3) | * Benefits may be subject to customary cost sharing for all other similar services or supplies within the policy. |  |  |
| RCW 48.21.143(5) | * Services must be covered when deemed medically necessary. |  |  |
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| **Disclosures** | Short Term Non- Qualifying- Coverage disclosure | WAC 284-43-8010(1) | All carriers offering or issuing a short-term limited duration medical plan with an effective date on or after January 1, 2019, must issue a standard disclosure form for each short-term limited duration medical plan in the same format and with the same content as the disclosure form included in this section. The standard disclosure form must be displayed prominently in the medical plan contract and in any application materials provided in connection with enrollment in such coverage, and must be provided as a distinct, separate document to the person upon initial receipt of the medical plan application. |  |  |
|  |  | WAC 284-43-8010(5) | The standard disclosure form must include, at a minimum, the information as shown in [WAC 284-43-8010(5).](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-8010) |  |  |
|  |  | WAC 284-43-8010(3) | * The type size and font of the standard disclosure form must be easily read and be no smaller than fourteen point. |  |  |
|  |  | WAC 284-43-8010(4) | * The standard disclosure form must not be used until it has been filed with and approved by the commissioner. |  |  |
|  | WAC 284-43-8010(2) | * Every carrier must have a mechanism in place to verify delivery of the standard disclosure form to the applicant and obtain the applicant's acknowledgment of receipt of the form. The carrier must retain each acknowledged disclosure form for five years. The forms must be available for review by the commissioner upon request. |  |  |
|  | Expiration date | WAC  284-43-8000(1)(c) | Must have an expiration date specified in the contract (taking into account any extensions that may be elected by the member with or without the carrier's consent) that is not more than three months after the original effective date of the policy, contract or agreement. |  |  |
| **Disclosures (Cont’d)** |  | WAC  284-43-8000(3) | * A short-term limited duration medical plan cannot be issued if it would result in a person being covered by a short-term limited duration medical plan for more than three months in any twelve-month period. |  |  |
|  | Health Care Benefit Managers | WAC 284-180-325(1) | If the plan utilizes Health Care Benefit Managers, a website link to the list of the Health Care Benefit Managers must be included in the plan for enrollees to access. See definition of “Health Care Benefit Manager in [E2SSB 5213](https://app.leg.wa.gov/billsummary?Year=2023&BillNumber=5213) |  |  |
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| **Hospital/**  **Surgical Services**  **Hospital/**  **Surgical Services (Cont’d)** | Coverage | WAC 284-43-8000(1)(a)(ii) | The coverage for hospital services must include: |  |  |
| Coverage (Cont’d) | WAC 284-43-8000  (1)(a)(ii)(A) | * Inpatient services and other miscellaneous services associated with admission to a hospital for diagnosis and treatment of a covered condition. "Miscellaneous services" includes medically necessary services delivered in a hospital setting, including professional services, anesthesia, facility fees, supplies, imaging, laboratory, pharmacy services and prescription drugs, treatments, therapy, or other services delivered on an inpatient basis; |  |  |
| WAC 284-43-8000  (1)(a)(ii)(B) | * Outpatient services, including medically necessary services ordered by the member's attending health care practitioner and rendered on an ambulatory basis for diagnosis and treatment of a covered condition, including office and clinic visits, diagnostic imaging, laboratory services, radiation therapy, physical/speech/occupational therapy, and hemodialysis; and |  |  |
| WAC 284-43-8000  (1)(a)(ii)(C) | * An extension of the medical plan term while hospitalized. If a member is hospitalized as an inpatient on the expiration date of the medical plan, the member's coverage under the medical plan will continue for purposes of that covered medical condition without payment of additional premium. The coverage will continue until the date the member is discharged from the hospital or until the date on which the applicable benefit maximums are reached, whichever occurs first. |  |  |
| WAC 284-43-8000  (1)(a)(iii) | The coverage for surgical services for diagnosis and treatment of a covered condition must include: |  |  |
|  |  |  | * inpatient and outpatient surgical services at a hospital, ambulatory surgical facility, surgical suite or provider's office. |  |  |
|  |  | "Surgical services" includes: |  |  |
|  |  | * medically necessary services delivered in a hospital, ambulatory surgical facility, surgical suite or provider's office related to provision of a surgical service, including professional services, anesthesiology, facility fees, supplies, laboratory, pharmacy services and prescription drugs related to, or required as a result of, the surgical procedure; and |  |  |
|  |  | WAC 284-43-8000 (1)(a)(iv) | * + The coverage for medical services for diagnosis and treatment of a covered condition must include office visits |  |  |
|  |  |  |  |  |  |
| **Preexisting Conditions** | Look-back period | WAC 284-43-8000(1)(b) | * Limits the look-back period for any preexisting medical condition, illness or injury to no more than twenty-four months prior to the date of application for the medical plan, if coverage of preexisting conditions is excluded. For purposes of this section, "preexisting medical condition" means a condition for which medical advice, diagnosis, care or treatment was received or recommended |  |  |
|  |  |  |  |  |  |
| **Experimental or Investigational**  **Treatment**  **Experimental or Investigational Treatment (Cont’d)** | Required definition | WAC 284-96-015(1) | * If the contract includes exclusion, reduction or limitation for services that are experimental or investigational, contract must include a definition of Experimental and Investigational services. |  |  |
| WAC 284-96-015(2) | * + The definition must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. |  |  |
| Disclosure of criteria for determining “experimental” or “investi-gational” | WAC 284-96-015(2) | * + - If the carrier or an affiliated entity is the authority making the determination, it must state the criteria it will utilize to make the determination. This requirement may be satisfied by using one or more of the following statements, or other similar statements: |  |  |
| WAC 284-96-015(2)(a) | * + - * "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious." |  |  |
| WAC  284-96-015(2)(b) | * + - * "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient." |  |  |
| Supporting documentation | WAC  284-96-377(2)(b) | * + The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary. |  |  |
| Time frames for denial | WAC 284-96-015(3) | * Whether the claim or request for preauthorization is made in writing or through other claim presentation or preauthorization procedures set out in the contract, any denial because of an experimental or investigational exclusion or limitation, must be done in writing within twenty working days of receipt of a fully documented request. The issuer may extend the review period beyond twenty days only with the informed written consent of the enrollee. |  |  |
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| **Fraud Statement (Application)** |  | RCW 48.135.080 | All outside market applications must contain a statement similar to the following: “It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.” This includes applications for plans normally sold on the Exchange which are purchased directly from the issuer. |  |  |
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| **Mandated Benefits** | Re-constructive Surgery following Mastectomy | RCW 48.21.230(1) | * Must provide coverage for reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury |  |  |
| RCW 48.21.230(2) | * Coverage for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. |  |  |
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| **Maternity and Newborn Coverage**  **Maternity and Newborn Coverage**  **(Cont’d)** | Women’s Health Care Practitioners Must Include | RCW 48.42.100(2) | * Health care practitioners that provide women's health care services must include, but need not be limited to: |  |  |
|  | * + Any generally recognized medical specialty of practitioners licensed under chapter [18.57](http://app.leg.wa.gov/RCW/default.aspx?cite=18.57) or [18.71](http://app.leg.wa.gov/RCW/default.aspx?cite=18.71) RCW who provides women's health care services; practitioners licensed under chapters [18.57A](http://app.leg.wa.gov/RCW/default.aspx?cite=18.57A) and [18.71A](http://app.leg.wa.gov/RCW/default.aspx?cite=18.71A) RCW when providing women's health care services; |  |  |
|  | * + midwives licensed under chapter [18.50](http://app.leg.wa.gov/RCW/default.aspx?cite=18.50) RCW; and |  |  |
|  | * + advanced registered nurse practitioner specialists in women's health and midwifery under chapter [18.79](http://app.leg.wa.gov/RCW/default.aspx?cite=18.79) RCW. |  |  |
| RCW 48.42.100(3); | * The Women's health care services women’s health care providers are allowed (if covered by the plan) to provide must include, but need not be limited to: Maternity care; reproductive health services; gynecological care; general examination; and preventive care as medically appropriate and medically appropriate follow-up visits; |  |  |
| Women’s Direct Access | RCW 48.42.100(4) and (5)(a) | * Female enrollees must have direct access to timely and appropriate covered women's health care services from the type of health care practitioner of their choice for appropriate covered women’s health care services without the necessity of prior referral from another type of health care practitioner. |  |  |
|  | RCW 48.42.100  (5)(c) | * Plan may restrict women’s direct access to in-network providers, but must not limit access to a subset of participating women's health care practitioners within the network. |  |  |
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| **Mental Health and Substance Use Disorder Services**  **Mental Health and Substance Use Disorder Services**  **(Cont’d)**  **Mental Health and Substance Use Disorder Services**  **(Cont’d)**  **Mental Health and Substance Use Disorder Services**  **(Cont’d)**  **Mental Health and Substance Use Disorder Services**  **(Cont’d)**  **Mental Health and Substance Use Disorder Services**  **(Cont’d)** | Benefit Mandate | RCW 48.20.580(2) | Contracts providing coverage for medical and surgical services shall provide coverage for mental health services. |  |  |
| Definitions | RCW 48.20.580 (1)(b) | For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005. |  |  |
| No “Blanket Limitations” | O.S.T. v. Regence BlueShield, | * Must provide benefits for mental health diagnoses (Diagnoses listed in the DSM) without any “blanket limitations” (e.g., age six and under) O.S.T. v. Regence BlueShield, No. 88940-6 (WN October 9, 2014). |  |  |
| Mental Health Parity Requirement  Mental Health Parity Requirement  (Cont’d)  Mental Health Parity Requirement  (Cont’d)  Mental Health Parity Requirement  (Cont’d) | 42 USC §300gg-26; RCW 48.21.241  (2)(c)(i) | * Contract may not apply any financial requirement or treatment limitation to MH/SUD benefits that is more restrictive than those applied to medical/surgical benefits. (Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)) |  |  |
|  | * + The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the contract. |  |  |
|  | * + If the contract has a maximum out-of-pocket limit or stop loss, it must be for medical, surgical, and mental health - it cannot have a separate MOOP or stop loss for mental health. |  |  |
|  | * + If the contract has any deductible, it must be for medical, surgical, and mental health – it cannot have a separate deductible for mental health. |  |  |
| 42 USC §300gg-26(3); RCW 48.20.580 (3)(a) | Contract may not apply any financial requirement or treatment limitation to MH/SUD benefits that is more restrictive than those applied to medical/surgical benefits. (Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)) |  |  |
| WAC 284-43-7020(1) | Plan must cover MH/SUD benefits in every classification in which medical/surgical benefits are provided. |  |  |
| WAC 284-43-7020(2) and (6)(a)(i and ii) | 6 Classifications: Inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. Outpatient services may be subclassified into office visits and all other outpatient items and services. |  |  |
| WAC 284-43-7020(3) | * In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits as applied to MH/SUD benefits. An issuer must assign covered intermediate MH/SUD benefits such as residential treatment, partial hospitalization, and intensive outpatient treatment, to the existing six classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a health plan classifies medical care in skilled nursing facilities as inpatient benefits, then it must also treat covered mental health care in residential treatment facilities as inpatient benefits. If a health plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well. |  |  |
| WAC 284-43-7020(5)(a) | Medical/surgical benefits and mental health or substance use disorder benefits cannot be categorized as being offered outside of these six classifications and therefore not subject to the parity analysis. A health plan or issuer must treat the least restrictive level of the financial requirement or quantitative treatment limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification. |  |  |
| WAC 284-43-7010; 284-43-7020(4) | Parity analysis must be done for each classification and applies to all treatment limitations (frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment). Look at: |  |  |
| WAC 284-43-7010; 284-43-7040 | * + Quantitative treatment limitations: expressed numerically (such as fifty outpatient visits per year)   Includes annual, episode, and lifetime day and visit limits. |  |  |
| WAC 284-43-7010 | * + Nonquantitative treatment limitations (“NQTL”): processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. Includes, but not limited to:     - Limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;     - Formulary design;     - Network tier design (if network is tiered)     - Methods for determining usual, customary, and reasonable charges;     - Use of fail-first policies or step therapy protocols;     - Restrictions based on geographic location, facility type, provider specialty, and other     - Criteria that limit scope or duration of benefits   A permanent exclusion of all benefits for a particular condition or disorder is not a NQTL; may be allowable if not otherwise prohibited |  |  |
| WAC 284-43-7060(2) | Plan standards: in-and-out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy. |  |  |
| WAC 284-43-7020(5)(b); | If a health plan or issuer classifies providers into tiers, and varies cost-sharing based on the different tiers, no financial requirement or treatment limitation on MH/SUD benefits may be more restrictive than what applies to substantially all medical/surgical benefits in that tier. |  |  |
| WAC 284-43-7060(1) | No NQTL may be imposed on MH/SUD in any classification unless any processes, strategies, evidentiary standards or other factors used to apply the NQTL to MH/SUD benefits are in parity with those used to apply it to medical/surgical benefits in the same classification. |  |  |
| RCW 48.20.580 (2)(a) | The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the disability insurance contract. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the disability insurance contract imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the disability insurance contract imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and |  |  |
|  | RCW 48.21.241 (2)(b) | Prescription drugs intended to treat any of the disorders covered in the definition to the same extent, and under the same terms and conditions, as other prescription drugs covered by the disability insurance contract. |  |  |
|  | Prohibited Exclusions | WAC 284-43-7080(1) | Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed. |  |  |
|  |  | WAC 284-43-7080(2) | If a service is prescribed for a mental health condition and is medically necessary, it may not be denied solely on the basis that it is part of a category of services or benefits that is excluded by the terms of the contract. |  |  |
|  |  | WAC 284-43-7080(3) | Benefits for MH/SUD may not be limited or denied based solely on age or condition. |  |  |
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| **Non-Discrimination** | Discrimination Prohibited | RCW 48.30.300 | No Issuer may refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation as defined in RCW [49.60.040](http://app.leg.wa.gov/RCW/default.aspx?cite=49.60.040), or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured. |  |  |
| **Non-Discrimination (Cont’d)** |  | RCW 48.43.0128 (1)(a) | A health plan may not, in its benefit design or implementation of its benefit design, discriminate against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; or |  |  |
|  |  | RCW 48.43.0128 (1)(b) | * discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. |  |  |
|  |  | RCW 48.43.0128 (2) | Nothing in this section may be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques. |  |  |
|  | Non-Discrimination Notice | RCW 48.43.0128; WAC 284-43-5980 | Must file a Non Discrimination Notice to include the insurance commissioner as the designated entity to file a complaint regarding compliance with RCW [48.43.0128](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.0128) and WAC [284-43-5935](http://app.leg.wa.gov/WAC/default.aspx?cite=284-43-5935) through [284-43-5980](https://app.leg.wa.gov/wac/default.aspx?cite=284-43-5980) and the federal Department of Health and Human Services, Office of Civil Rights as the designated entity to file a complaint regarding compliance related to the issuer's compliance with 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act). |  |  |
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| **PKU Phenylketonuria Formula** |  | RCW 48.21.300 | * Coverage must be provided for the formulas necessary for the treatment of phenylketonuria. |  |  |
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| **Prescription Medications**  **Prescription Medications (Cont’d)** | Coverage of drugs for “off-label” use |  | **Requirements for plans that cover prescription drugs. If plan does not cover prescription drugs, skip this section.** |  |  |
| WAC 284-30-450  (4)(a)(i) | * Inurance policy or contract must not exclude coverage of any FDA-approved prescription drug for a particular indication on the grounds that the drug has not been approved by the FDA for that indication, if it is recognized as effective for treatment of that indication:   + In one of the standard reference compendia; |  |  |
| WAC 284-30-450  (4)(a)(ii) | * + In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or |  |  |
| (4)(a)(iii) | * + By the Federal Secretary of Health and Human Services. |  |  |
| WAC 284-30-450(4)(b) | * Coverage of a drug for such “off-label” use must also include medically necessary services associated with the administration of the drug. |  |  |
| WAC 284-30-450(4)(c) | * Coverage for off-label use is not required when the FDA has determined its use to be contra-indicated. |  |  |
| WAC 284-30-450(4)(d) | * Coverage is not required for experimental drugs not otherwise approved for any indication by the FDA. |  |  |
| Benefit Mandates | RCW 48.21.300(2) | State benefit requirements classified to the prescription drug services category include:   * Medical formula to treat PKU; |  |  |
| RCW  48.21.143  (2)(a) | * Diabetes supplies ordered by the physician (Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary); |  |  |
| RCW 48.21.241  (2)(c)(ii) | * Mental health prescription drugs to the same extent, and under the same terms and conditions, as other prescription drugs covered by the plan. |  |  |
| Pharmacists – Eye Drop Refills | RCW 18.64.530 | Forms may not include any provision conflicting with the following:  A pharmacist is authorized, without consulting a physician or obtaining a new prescription or refill authorization from a physician, to provide for one early refill of a prescription for topical ophthalmic products if: |  |  |
| RCW 18.64.530(1) | • The refill is requested by a patient at or after seventy percent of the predicted days of use of |  |  |
| 18.64.530  (1)(a) | * + The date the original prescription was dispensed to the patient; or |  |  |
| 18.64.530  (1)(b) | * + The date that the last refill of the prescription was dispensed to the patient; |  |  |
| RCW 18.64.530(2) | * + The prescriber indicates on the original prescription that a specific number of refills will be needed; and |  |  |
| RCW 18.64.530(3) | * + The refill does not exceed the number of refills that the prescriber indicated. |  |  |
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| **Preventive Screening** | Benefit Mandates | RCW 48.21.227(1); RCW 48.43.078 | * Mammogram services, both diagnostic and screening, includingTomosynthesis. |  |  |
| * + Coverage of mammograms may be subject to standard policy provisions applicable to other diagnostic X-ray benefits such as deductible or copayment provisions. |  |  |
| RCW 48.21.392 | * Prostate cancer screening if delivered upon the recommendation of the patient’s physician, ARNP, or Physician Assistant. |  |  |
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| **Provider Requirements** | Second opinion | WAC  284-96-020(1)(a)(ii) | * For Temporomandibular joint disorders, coverage for medical services must include a second opinion |  |  |
|  |  | WAC  284-96-020(1)(a)(i) | * May require that services either be rendered or referred by the covered individual's primary care physician |  |  |
|  |  | WAC  284-96-020(1)(a)(ii) | * May not impose any charge or cost for the second opinion other than the cost imposed for the same service in otherwise similar circumstances. |  |  |
|  |  | WAC  284-96-020(1)(a)(iii) | * May require prenotification or preauthorization |  |  |
|  | Services by certain providers | RCW 48.21.141(1) and (2); RCW 48.21.130(1) and (2) | Contract must cover services performed by a Registered Nurse, Advanced Registered Nurse Practitioner, or podiatrist if: |  |  |
| * the service is within the scope of the provider’s license, and |  |  |
| * the contract would have covered the service if it had been performed by a physician licensed under Chapter 18.71 RCW. |  |  |
| Denturist if Dental Covered | RCW 48.21.148 | If the contract offers dental coverage, Denturist must be able to provide services within the scope of their license if the plan would provide the same benefits performed by a dentist. |  |  |
| Coverage of Chiropractic care | RCW 48.21.142(1) and (2) | Benefits for services provided by a chiropractor cannot be denied on the basis that a service is not performed by a physician licensed under Chapter 18.57 or 18.71 RCW. |  |  |
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| **Required Offer** | Offer coverage TMJ | WAC 284-43-8000(2) | Any carrier offering a short-term limited duration medical plan must offer at least one such plan with a deductible stated on a per person basis of two thousand dollars or less. |  |  |
|  | RCW 48.21.320(1) | Insurers must offer optional coverage for treatment of Temporomandibular Joint Disorder (TMJ) |  |  |
| RCW 48.21.320(1)(a) | * Insurers offering medical coverage only may limit benefits in such coverages to medical services related to treatment of temporomandibular joint disorders. No insurer offering medical coverage only may define all temporomandibular joint disorders as purely dental in nature. |  |  |
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| **Standard of Care** |  | RCW 48.43.545 | Issuer may not attempt to waive, shift, or modify its responsibility to adhere to the accepted standard of care for health care providers when arranging for medically necessary health care for enrollees. Issuer is liable for any harm proximately caused by its failure to follow the standard of care when the failure results in denial, delay, or modification of the health care service recommended for, or furnished to, the enrollee. This includes all the issuer’s employees, agents, or ostensible agents. |  |  |
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| **Subrogation** |  | Thiringer v. American  Motors Ins.,  91 WN 2d 215, 588 P.2d 191 (1978); Mahler v. Szucs | If the contract includes a subrogation provision, it must: |  |  |
| * Make clear that the issuer is entitled only to excess after the enrollee is fully compensated; and   Inform enrollee that legal expenses will be apportioned equitably |  |  |
| The policy may not:   * Have any provision which would inappropriately require full reimbursement for all medical expenses * The contract cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party |  |  |
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| **Transgender Services** |  | 42 USC §18116;  RCW 48.30.300;  RCW 49.60.040 (25) and (26) | Broad exclusions of coverage, and denial of a medically necessary service, on the basis of gender identity are prohibited. This prohibition applies in the issuance, cancellation, or renewal of any contract of insurance, as well as amount of benefits payable, or any term, rate, condition, or type of coverage offered. A plan may not limit or exclude otherwise covered services on the basis that the insured/enrollee identifies as a transgender or requires the service for treatment of gender identity disorder or gender dysphoria.  45 CFR §156.200(e); 45 CFR §92.206 and 92.207 (especially section (b)(4)) |  |  |
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| **Unfair and Discriminatory Practices** | False Represen-tation Prohibited | RCW 48.18.480;  RCW 48.30.040;  48.30.300 | No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising on behalf of an Issuer. Nor shall the terms of a contract be misrepresented or misleading comparisons be made to induce a member to terminate or retain a contract or membership. |  |  |
|  | Discrimination Prohibited | RCW 48.30.300 | No Issuer may refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation as defined in RCW [49.60.040](http://app.leg.wa.gov/RCW/default.aspx?cite=49.60.040), or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured. |  |  |
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