**ANALYST CHECKLIST**

**HMO – INDIVIDUAL MAJOR MEDICAL 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 48.46.060, RCW 48.43.715

WAC 284-43-5622, WAC 284-43-5642, WAC 284-43-5702, WAC 284-43-5782

| **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 | WAC  284-46-500(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  284-46-500(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. |  |  |
| Requirement to cover home care in lieu of hospitalization (Cont’d) | WAC 284-46-500(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 284-46-500(4) | * HMO 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 284-46-500(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. |  |  |
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| **Ambulatory Patient Services (EHB)**  **Ambulatory Patient Services (EHB) (Cont’d)**  **Ambulatory Patient Services (EHB) (Cont’d)**  **Ambulatory Patient Services (EHB) (Cont’d)** | General Ambulatory Patient Services Requirements  General Ambulatory Patient Services Requirements  (Cont’d) | WAC 284-43-5642(1);;  42 USC §18021(a)(1)(B);  42 USC 18022(b)(1)(A) | Plan must cover "ambulatory patient services" substantially equal to the base-benchmark plan. In determining AV, an issuer must classify as "ambulatory patient services" those medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury. |  |  |
| WAC 284-43-5642(1)(a)(i) | Plan must cover the following, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:   * Home and outpatient dialysis services; |  |  |
| WAC 284-43-5642(1)(a)(ii) | * Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with state law. |  |  |
| WAC 284-43-5642(1)(a)(iii) | * Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies; |  |  |
| WAC 284-43-5642(1)(a)(iv) | * Urgent care center visits, including provider services, facility costs and supplies; |  |  |
| WAC 284-43-5642(1)(a)(v) | * Ambulatory surgical center professional services, including anesthesiology, professional surgical services, surgical supplies and facility costs; |  |  |
| WAC 284-43-5642(1)(a)(vi) | * Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and |  |  |
| WAC 284-43-5642(1)(a)(vii) | * Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices. |  |  |
| WAC 284-43-5642(b)(iii)  42 USC §18021  (a)(1)(B); 42 USC 18022(b)(1)(I) | * Plan must cover oral surgery related to trauma and injury. Plan may not exclude services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease; |  |  |
| 45 CFR 147.130 | * Plan must cover obesity or weight reduction or control services for children ages six and over who qualify as obese, and adult patients who have a body mass index of 30 kg/meter squared or higher. |  |  |
| WAC 284-43-5642  (1)(b)(viii)  (A) | * + Must cover intensive, multicomponent weight management behavioral interventions without cost-sharing. Services include, but are not limited to:     - Group and individual sessions of high intensity; and |  |  |
| (B) | * + - Behavioral management activities, such as weight-loss goals. |  |  |
| Optional Ambulatory Services (not to be included in establishing AV for the Ambulatory Services category) | WAC 284-43-5642 (1)(b)(i) and (ii) | Plan may, but is not required to, cover:   * Infertility treatment and reversal of voluntary sterilization; * Routine foot care for those that are not diabetic; |  |  |
| WAC 284-43-5642(1)(b)(iii) | * Dental services following injury to sound natural teeth. (Must cover services listed above in required services.) |
| (iv) | * Private duty nursing for hospice care and home health care; |  |  |
| (v) | * Adult dental care and orthodontia delivered by a dentist or in a dentist's office; |  |  |
| (vi) | * Nonskilled care and help with activities of daily living; |  |  |
| WAC 284-43-5642(1)(b)(vii) | * Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them. Plans must cover cochlear implants and hearing screening tests that are required under the preventive services category, unless coverage for these services and devices are required as part of and classified to another EHB category; and |  |  |
| 284-43-5642  (1)(b)(viii) | * Obesity or weight reduction or control other than covered nutritional counseling. (Must cover services listed above as required services.) |  |  |
| Allowable Limitations on Ambulatory Services | WAC 284-43-5642(1)(c)(i) | The base-benchmark plan's visit limitations on services in the ambulatory patient services category include:   * Ten spinal manipulation services per calendar year without referral; |  |  |
| (ii) | * Twelve acupuncture services per calendar year without referral; |  |  |
| WAC 284-43-5642(1)(c)(iii) | * Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime (these fourteen days of respite care services may be classified as ambulatory care services or hospitalization services, but not both); and |  |  |
| (iv) | * One hundred thirty visits per calendar year for home health care. |  |  |
| State Benefit Requirements Classified to Ambulatory Services Category | WAC 284-43-5642(1)(d)(i) | Plan must include the following State benefit requirements classified to the ambulatory patient services category:   * Chiropractic care; |  |  |
| WAC 284-43-5642(1)(d)(ii) | * TMJ disorder treatment; * and |  |  |
| RCW 48.46.272; WAC 284-43-5642(1)(d)(iii) | * Diabetes-related care and supplies (RCW [48.20.391](http://app.leg.wa.gov/RCW/default.aspx?cite=48.20.391), [48.44.315](http://app.leg.wa.gov/RCW/default.aspx?cite=48.44.315), and [48.46.272](http://app.leg.wa.gov/RCW/default.aspx?cite=48.46.272)). |  |  |
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| **Appeals Procedures**  *Resources:*[ACA FAQ I](http://www.dol.gov/ebsa/faqs/faq-aca.html)**;** [DOL FAQs on Claims](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html) | Internal appeals / review of adverse benefit decisions under **Both** Grand-fathered and Non-Grand-fathered plans | 42 U.S.C.  §300gg-19 (a)  45 C.F.R. §147.136(b)  RCW 48.43.530(1)  WAC 284-43-3030(1) | Does the plan have a fully operational, comprehensive process for review of appeals / adverse benefit determinations? |  |  |
|  |  | WAC 284-43-4020(1) | The issuer’s process for review of adverse benefit determinations must meet accepted national certification standards such as those used by the National Committee for Quality Assurance, except as otherwise required under Chapter 284-43 WAC. |  |  |
|  |  | RCW 48.43.530 (8)  WAC 284-43-3050  WAC  284-43-4020(2)(a) | Does the contract provide a clear explanation of the appeal / review of adverse benefit determination process? |  |  |
|  |  | RCW 48.43.530(9)  WAC 284-43-3050(4)  WAC 284-43-4020(2)(b) | * The process must be accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file an appeal or review of adverse benefit determination. |  |  |
| **Appeals Procedures (Cont’d)** | Internal appeals / review of adverse benefit decisions under **Both** Grand-fathered and Non-Grand- | RCW 48.43.530(3) | Does the contract notify the enrollee of the issuer’s responsibility to provide written notice to the enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility? |  |  |
|  | fathered plans | RCW  48.43.530(4)  (a)and (b) | * An issuer must process as an appeal / review of adverse benefit determination an enrollee's written or oral request that the issuer reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. |  |  |
|  |  | RCW  48.43.530(4)(c) | * The issuer may not require that an enrollee file a complaint or grievance prior to seeking an appeal or review of an adverse benefit determination. |  |  |
|  | Internal Appeals under Grand-fathered Health Plan | WAC 284-43-3030(3) | Does the contract notify the enrollee that, when the enrollee requests reconsideration of a decision to modify, reduce, or terminate an otherwise covered health service that the enrollee is receiving through the health plan, based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the issuer must continue to provide that health service until the appeal / review of adverse benefit determination is resolved? |  |  |
|  |  | RCW 48.43.530(5)(b)  WAC 284-43-3050(5) WAC 284-43-4020(2)(d) | The issuer must assist the enrollee with the appeal process. |  |  |
| **Appeals Procedures (Cont’d)** | Internal Appeals under Grand-fathered | RCW 48.43.530(5)(d)  WAC 284-43-4020(2)(e) | The issuer must cooperate with any representative authorized in writing by the enrollee. |  |  |
|  | Health Plans (Cont’d | RCW 48.43.530(5)(e)  WAC 284-43-4020(2)(f)  WAC 284-43-4040(5) | The issuer must consider all information submitted by the enrollee or representative. |  |  |
|  |  | RCW 48.43.530(5)(f) WAC 284-43-4020(2)(g) | The issuer must investigate and resolve all appeals / requests for review of adverse benefit determination. |  |  |
|  |  | RCW 48.43.530(4)(a) | The review of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including admission to, or continued stay in, a health care facility, is processed as an appeal. |  |  |
|  |  | WAC  284-43-4020(2)(c) | The issuer must:   * respond to oral and written appeals in a timely and thorough manner; * notify the enrollee that an appeal has been received. |  |  |
|  |  | WAC 284-43-4020(2)(h) | Provide information on the enrollee's right to obtain second opinions. |  |  |
| **Appeals Procedures (Cont’d)** | Internal Appeals under Grand-fathered | WAC 284-43-4040(1) | An enrollee or the enrollee's representative, including the treating provider (regardless of whether the provider is contracted with the issuer) acting on behalf of the enrollee may appeal an adverse determination in writing.   * The issuer must reconsider the adverse determination and notify the enrollee of its decision within fourteen days of receipt of the appeal. * Issuer can extend time to complete the appeal up to a max of 30 days if it notifies the enrollee an extension is necessary;   Issuer can delay the decision beyond thirty days ONLY with the informed, written consent of the enrollee. |  |  |
|  | Health Plans (Cont’d | WAC 284-43-4040(2) | Issuer must expedite either a written or oral appeal whenever delay would jeopardize the enrollee's life or materially jeopardize the enrollee's health.   * Must issue its decision no later than seventy-two hours after receipt of the appeal. * If the treating health care provider determines that delay could jeopardize the enrollee's health or ability to regain maximum function, the issuer must presume the need for expeditious review, including the need for expedited determination in any independent review under WAC 284-43-630. |  |  |
|  |  | WAC 284-43-4040(4) | Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease. |  |  |
|  |  | WAC 284-43-4040(6) | The carrier shall issue to affected parties and to any provider acting on behalf of the enrollee a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. |  |  |
| **Appeals Procedures (Cont’d)** | Internal Reviews of Adverse | WAC 284-43-3110 | Carrier’s process for review of an adverse benefit determination must include an opportunity for internal review. |  |  |
|  | Benefit Determi-nations under Non-Grand-fathered Health Plans | 29 C.F.R.  §2560.503-1(m)(4)  RCW 48.43.530(4)(b) | The review of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including admission to, or continued stay in, a health care facility, is processed as a review of an adverse benefit determination, as defined in [RCW 48.43.005(2)](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.005). |  |  |
|  |  | 45 C.F.R. §147.136(a)(2)(i)  RCW 48.43.530(11)  WAC 284-43-3110(8) | A denial or rescission of coverage is subject to review of adverse benefit determination, whether or not the rescission has an adverse effect on any particular benefit at the time. |  |  |
|  |  | WAC 284-43-3030(4) | The issuer must accept a request for internal review of adverse benefit determination if it is received within 180 days of the enrollee’s receipt of the determination. |  |  |
|  |  | RCW 48.43.530(5)(a) | In order to process an adverse benefit determination, the issuer must:  Provide written notice of receipt to the enrollee within 72 hours after a request for review of the adverse benefit decision is received; |  |  |
|  |  | RCW 48.43.530(5)(g)  WAC 284-43-3030(4) | Provide written notice of its resolution to the enrollee and, with the permission of the enrollee, to the enrollee's providers. |  |  |
|  |  | WAC 284-43-3110(1) | * The issuer must notify the appellant of the review decision within fourteen days of receipt of the request for review, unless the adverse benefit determination involves an experimental or investigational treatment. |  |  |
| **Appeals Procedures (Cont’d)** | Internal Reviews of Adverse  Benefit Determi-nations under Non-Grand-fathered Health Plans (Cont’d) | WAC 284-43-3110(2) | * For good cause, an issuer may extend the time it takes to make a review determination by up to sixteen additional days without the appellant's written consent, but must notify appellant of the extension and the reason for the extension. * The issuer may request further extension of its response time only if the appellant consents to a specific request for a further extension, the consent is reduced to writing, and includes a specific agreed-upon date for determination. In its request for the appellant's consent, the issuer must explain that waiver of the response time is not compulsory. |  |  |
|  |  | WAC 284-43-3110(3) | * The issuer must provide the appellant with any new or additional evidence or rationale considered, whether relied upon, generated by, or at the direction of the issuer in connection with the claim. This must be provided free of charge to the appellant and sufficiently in advance of the date the notice of final internal review must be provided. * If the appellant requests an extension in order to respond to any new or additional rationale or evidence, the issuer must extend the determination date for a reasonable amount of time, which may not be less than two days. |  |  |
|  |  | WAC 284-43-3110(4) | * The review process must provide the appellant with the opportunity to submit information, documents, written comments, records, evidence, and testimony, including those obtained through a second opinion. |  |  |
|  |  | * The appellant must have the right to review the issuer's file and obtain a free copy of all documents, records, and information relevant to any claim that is the subject of the determination being appealed. |  |  |
| **Appeals Procedures**  **(Cont’d)** | Internal Reviews of  Adverse Benefit | WAC 284-43-3110(5) | * The internal review process must include the requirement that the issuer affirmatively review and investigate the appealed determination, and consider all information submitted by the appellant prior to issuing a determination. |  |  |
|  | Determi-nations under Non-Grand-  fathered Health Plans  (Cont’d) | WAC 284-43-3110(6) | * Review of adverse determinations must be performed by health care providers or staff who were not involved in the initial decision, and who are not subordinates of the persons involved in the initial decision. If the determination involves, even in part, medical judgment, the reviewer must be or must consult with a health care professional who has appropriate training and experience in the field of medicine encompassing the appellant's condition or disease and make a determination that is within the clinical standard of care for an appellant's disease or condition. |  |  |
|  |  | WAC 284-43-3110(7) | * The internal review process for group health plans may require two levels of internal review prior to bringing a civil action. |  |  |
|  |  | WAC 284-43-3050(3) | Does the contract include information about the availability of Washington's designated ombudsman's office, the services it offers, and contact information?  Does the contract specifically direct appellants to the OIC's consumer protection division for assistance with questions and complaints? |  |  |
|  |  | WAC 284-43-3050(4)(b) | * Does the contract’s notice of the process for review of adverse benefit decisions conform to federal requirements to provide this notice in a culturally and linguistically appropriate manner to those seeking review? |  |  |
|  |  | WAC 284-43-3050(4)(c) | * This requirement is satisfied if the National Commission on Quality Assurance certifies the carrier is in compliance with this standard as part of the accreditation process. |  |  |
|  |  | WAC 284-43-3050(5) | Contract may not contain procedures or practices that discourage an appellant from any type of adverse benefit determination review. |  |  |
| **Appeals Procedures (Cont’d)** | Internal Reviews of Adverse Benefit | WAC 284-43-3050(6) | Issuer may reverse its initial adverse benefit determination at any time during the review process. In that case, issuer must provide written or electronic notification immediately, but in no event more than two business days of making the decision. |  |  |
|  | Determi-nations under | WAC 284-43-3090(1) | An issuer can provide documents related to adverse benefit determinations and review of adverse benefit determinations electronically, but ONLY IF: |  |  |
|  | Non-Grand-fathered Health Plans | WAC 284-43-3090(2)(a) | * The enrollee affirmatively consents, in electronic or nonelectronic form, to receiving documents through electronic media and has not withdrawn such consent. |  |  |
|  | (Cont’d) | WAC 284-43-3090(2)(b) | * If the documents are to be furnished electronically, the appellant must have affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates his ability to access the electronically-provided information, and must have provided an address for receipt of electronically furnished documents; |  |  |
|  |  | WAC 284-43-3090(2)(c) | * Prior to consenting, the enrollee must be provided, in electronic or nonelectronic form, a clear and conspicuous statement indicating: |  |  |
|  |  | WAC 284-43-3090(2)(c)(i) | * + The types of documents to which the consent would apply; |  |  |
|  |  | WAC 284-43-3090(2)(c)(ii) | * + That consent can be withdrawn at any time without charge; |  |  |
|  |  | WAC 284-43-3090(2)(c)(iii) | * + The procedures for withdrawing consent and for updating the individual's electronic address for receipt of electronically furnished documents or other information; |  |  |
|  |  | WAC 284-43-3090(2)(c)(iv) | * + The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and |  |  |
|  |  | WAC 284-43-3090(2)(c)(v) | * + Any hardware and software requirements for accessing and retaining the documents. |  |  |
| **Appeals Procedures (Cont’d)** | Internal Reviews of Adverse Benefit Determi-nations under Non-Grand-fathered | WAC 284-43-  3090(3) | After consent, if a change in hardware or software requirements to access or retain electronic documents creates a material risk that an enrollee will be unable to access or retain such documents, the issuer must provide information about the new requirements and the opportunity to withdraw consent without consequences. The issuer must request and receive a new consent to electronically provided documents, following such a hardware or software requirement change. |  |  |
|  | Health Plans  (Cont’d) | WAC 284-43-3090(1)(c) and (d) | With respect to documents regarding adverse benefit determinations and review of such determinations, an issuer furnishing such documents electronically is deemed to satisfy the notice and disclosure requirements if:   * at the time a document is furnished electronically, the issuer provides notice (in electronic or nonelectronic form) that apprises the recipient of: * the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., “the attached document describes the internal review process used by your plan”); and * The recipient’s right to request and obtain a paper version of such document; AND   The issuer furnishes the appellant or their representative with a paper version of the electronically furnished documents if requested. |  |  |
|  | Expedited Internal Reviews of Adverse | RCW 48.43.530(5)(c)  WAC 284-43-3170(1) | The Issuer must provide an expedited review process at any point in the review process IF: |  |  |
|  | Benefit Determin-ations under | WAC 284-43-3170(1)(a) | * The appellant is currently receiving or is prescribed treatment or benefits that would end due to the adverse benefit determination; OR |  |  |
|  | Non-Grand-  Fathered Plans | WAC 284-43-3170(1)(c) | * The ordering provider or the issuer's medical director reasonably determines that following the normal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or would subject the appellant to severe and intolerable pain; OR |  |  |
| **Appeals Procedures (Cont’d)** | Expedited Internal Reviews of Adverse | WAC 284-43-3170(1)(b) | * The determination is related to an issue related to admission, availability of care, continued stay, or emergency health care services where the appellant has not been discharged from the emergency room or transport service. |  |  |
|  | Benefit Determi-nations under Non-  Grand- | WAC 284-43-3170(5) | If the treating health care provider determines that a delay could jeopardize the enrollee's health or ability to regain maximum function, the issuer must presume the need for expedited review, and treat the review request as such, including the need for an expedited determination of an external review under RCW 48.43.535. |  |  |
|  | Fathered Plans (Cont’d) | WAC 284-43-3170(2) | Appellant is not entitled to expedited review if the treatment has already been delivered and the review involves payment for the delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness, or disease. |  |  |
|  |  | WAC 284-43-3170(3) | An expedited review may be filed by an appellant, the appellant's authorized representative, or the appellant's provider orally, or in writing. |  |  |
|  |  | RCW 48.43.530(5)(c)  WAC 284-43-3170(4) | The issuer must respond as expeditiously as possible to an expedited review request, preferably within twenty-four hours, but in no case longer than seventy-two hours. The decision regarding an expedited review of adverse benefit determination must be made within 72 hours of the date the request for review is received. |  |  |
|  |  | WAC 284-43-3170(4)(a) | * The issuer's response to an expedited review request may be delivered orally, and must be reduced to and issued in writing not later than 72 hours after the date of the decision. Regardless of who makes the issuer's determination, the time frame for providing a response to an expedited review request begins when the issuer first receives the request. |  |  |
| **Appeals Procedures (Cont’d)** | Expedited Internal Reviews of Adverse | WAC 284-43-3170(4)(b) | * If the issuer requires additional information to determine whether the service being reviewed is covered, the issuer must request such information as soon as possible after receiving the request for expedited review. |  |  |
|  | Benefit Determin-ations under | WAC 284-43-3170(6) | An issuer may require exhaustion of the internal appeal process before appellant may request external review in urgent care situations that justify expedited review. |  |  |
|  | Non-Grand-  Fathered Plans (Cont’d) | WAC 284-43-3170(7) | Expedited review must be conducted by appropriate clinician(s) in the same or similar specialty as would typically manage the case being reviewed. The clinician(s) must not have been involved in making the initial adverse determination. |  |  |
|  | Independent Review of appeals(“IRO”) for **both** Grand- | 42 U.S.C.  §300gg-19(b)  RCW 48.43.535(2) | An enrollee may seek review by a certified independent review organization of an issuer's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting the issuer's internal appeals / review of adverse benefit decision process and receiving a decision that is unfavorable to the enrollee. |  |  |
|  | fathered and Non-Grand-fathered plans | RCW 48.43.535(2)  WAC 284-43-3130(1) | * Enrollee may also seek review by a certified independent review organization after the carrier has exceeded the timelines provided in RCW 48.43.530, without good cause and without reaching a decision. |  |  |
|  |  | WAC 284-43A-140(2) | Issuers must use the rotational registry system of certified independent review organizations (IROs) established by OIC, and may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in [WAC 284-43A-050](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43A-050) |  |  |
|  |  | WAC 284-43A-140(4)(a) | * Issuers must make available to the enrollee and to any provider acting on behalf of the enrollee all materials provided to the IRO. |  |  |
| **Appeals Procedures (Cont’d)** | Independent Review of appeals (“IRO”) for **both** Grand-fathered and | WAC  284-43A-140(4)(c) | * Issuers must provide IROs with all relevant clinical review criteria used by the issuer and other relevant medical, scientific, and cost-effectiveness evidence, the attending or ordering provider's recommendations, and a copy of the terms and conditions of coverage under the relevant health plan. |  |  |
|  | Non-Grand-fathered plans (Cont’d) | RCW 48.43.535(5) | Enrollees must have at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review. |  |  |
|  |  | RCW 48.43.535(7)(a) | An enrollee or carrier may request an expedited external review if the issuer’s decision to deny, modify, reduce, or terminate coverage or payment for a health care service:   * concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or * involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. * The independent review organization must make its determination to uphold or reverse the issuer’s decision, and notify the enrollee and the issuer of its determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. |  |  |
|  |  | RCW 48.43.535(8) | If the notice is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision. |  |  |
| **Appeals Procedures (Cont’d)** | Independent Review of appeals (“IRO”) for **both** Grand-fathered and Non-Grand-fathered plans (Cont’d) | RCW  48.43.535(9) | When an enrollee requests independent review of an issuer's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the issuer's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the issuer must continue to provide the health service if requested by the enrollee until a determination is made.   * If the determination affirms the issuer's decision, the enrollee may be responsible for the cost of the continued health service.   Note: Washington has demonstrated that it meets parallel process to federal external review standards, so a plan does not have to separately follow federal law. See chart: [www.cms.gov/cciio/resources/files/external\_appeals.html](http://www.cms.gov/cciio/resources/files/external_appeals.html). |  |  |
|  | Independent Review of health care disputes | WAC  284-43-3150(5) | Appellant must be given up to 180 days following receipt of written notification of the internal review determination to file a request for external review. If external review is not requested, the internal review decision is final and binding. |  |  |
|  | (“IRO”) for Grand-fathered plans | RCW 48.43.535(2)  WAC  284-43-3130(1) | If the issuer fails to strictly adhere to its internal review requirements, the internal review process is deemed exhausted, and the appellant may request external review without receiving an internal review determination. |  |  |
|  |  | WAC 284-43-3130(2) | Issuer may challenge external review requested due to failure to adhere to requirements (either to the IRO or to a court) on the basis that the issuer’s violations are *de minimis*, and do not prejudice the appellant. |  |  |
|  |  | WAC 284-43-3130(2)(a) | * Exception applies only if the IRO or court determines that the issuer has demonstrated that the violation was for good cause or was due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and appellant. |  |  |
| **Appeals Procedures (Cont’d)** | Independent Review of health care | WAC 284-43-3130(2)(b) | * Exception is not available, and the challenge may not be sustained, if the violation is part of a pattern or practice of violations by the carrier or health plan. |  |  |
|  | disputes (“IRO”) for Grand-fathered plans (Cont’d) | WAC 284-43-3130(3) | Appellant may request a written explanation of the violation from the carrier and the carrier must provide such explanation within ten calendar days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. |  |  |
|  |  | WAC 284-43-3130(4) | If the challenge is successful and the IRO or court determines that the internal review process is not exhausted, the issuer must provide the appellant with notice that they may resubmit and pursue the internal appeal within a reasonable time, not to exceed ten days, of receiving the IRO’s determination, or entry of the court's final order. |  |  |
|  | External Review of Adverse Benefit Determi-nations for | WAC  284-43A-140(1) | Appellants must be provided the right to external review of adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria.   * Issuer may not establish a minimum dollar amount requirement for an appellant to seek external independent review. |  |  |
|  | Non-Grand-Fathered Plans | WAC 284-43A-140(4)(b) | * IRO review must be provided without imposing any cost to the appellant or their provider. |  |  |
|  |  | WAC 284-43A-140(4)(d) | * Within one day of selecting the IRO, the issuer must notify the appellant of the name of the IRO and its contact information. |  |  |
|  |  |  | * The notice must explain that the IRO will accept additional information in writing from the appellant for up to five business days after it receives the assignment, which the IRO must consider when conducting its review. |  |  |
| **Appeals Procedures (Cont’d)** | External Review of Adverse Benefit Determi- |  | An issuer may waive a requirement that internal appeals must be exhausted before an appellant may proceed to independent review of an adverse determination. |  |  |
|  | nations for Non-Grand-Fathered Plans (Cont’d) |  | Upon receipt of this information provided by the appellant to the IRO, an issuer may reverse its final internal adverse determination. If it does so, it must immediately notify the IRO and the appellant. |  |  |
|  | Concurrent Expedited Review of Adverse Benefit Determin-ations for Non-Grand-Fathered Plans | WAC 284-43-3190(1) | Issuer must offer the right to request concurrent expedited internal and external review of adverse benefit determinations.   * "Concurrent expedited review" means initiation of both the internal and external expedited review simultaneously. This is review of either utilization review decisions or treatment decisions during a patient's stay or course of treatment in an inpatient or outpatient health care setting so that the final adverse benefit determination is reached as expeditiously as possible. |  |  |
|  |  | WAC 284-43-3190(2) | When concurrent expedited review is requested, issuer may not make the determinations consecutively. The requisite timelines must be applied concurrently. |  |  |
|  |  | WAC 284-43-3190(3) | Issuer may deny a request for concurrent expedited review only if the conditions for expedited review are not met. Issuer may not require exhaustion of internal review if an appellant requests concurrent expedited review. |  |  |
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| **Applications** | Carrier must Submit Application to be Used for Direct Sale of Exchange-only Plans | 45 CFR 147.104(a) | The federal statutory guaranteed issue requirement and implementing rule do not distinguish between exchange and non-exchange products and do not except plans from the requirement that all products approved for sale in the individual market must be made available to any individual who applies for any of those products inside or outside the exchange. Carriers must submit an application to be used for the direct sale of Exchange-only products outside of the Exchange when requested. |  |  |
|  | Fraud Statement | 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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| **Clinical Trials**  **Clinical Trials (Cont’d)** | Requirements for coverage  Requirements for coverage  (Cont’d) | WAC 284-43-5420 | * Plan must not restrict coverage of routine patient costs for enrollees who participate in a clinical trial. |  |  |
| WAC 284-43-5420 | * + "Routine costs" means items and services that are consistent with and typically covered by the plan for an enrollee who is not enrolled in a clinical trial. |  |  |
| WAC 284-43-5420 | * Plan may apply limitations and requirements related to use of network services. |  |  |
| WAC 284-43-5420(1) | * Plan may require enrollees to meet eligibility requirements of the clinical trial protocol, including medical and scientific information establishing that the enrollee meets the requirements, unless the enrollee is referred to the clinical trial by an in-network provider. |  |  |
| WAC 284-43-5420(2) | * Plan must cover the cost of prescription medication used for direct clinical management of the enrollee, unless the trial is for the investigation of the medication or the medication is typically provided free by the research sponsors for anyone in the trial. |  |  |
| WAC 284-43-5420(3)(a) | * Exceptions: The requirement does not apply to:   + A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; |  |  |
| WAC 284-43-5420(3)(b) | * + Items and services provided solely to satisfy data collection and analysis needs; |  |  |
| WAC 284-43-5420(3)(c) | * + Items and services that are not used in the direct clinical management of the enrollee; or   + The investigational item, device, or service itself. |  |  |
| WAC 284-43-5420(4)  WAC 284-43-5420(4)(a) | * “Clinical trial” means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:   + One of the National Institutes of Health (NIH); |  |  |
| WAC 284-43-5420(4)(b)  WAC 284-43-5420(4)(c) | * + An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;   + The federal Departments of Veterans Affairs or Defense; |  |  |
| WAC 284-43-5420(4)(d) | * + An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; or |  |  |
| WAC 284-43-5420(4)(e) | * + A qualified research entity that meets the criteria for NIH Center Support Grant eligibility. |  |  |
| WAC 284-43-5420 (4)(e) | * "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. |  |  |
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| **Colorectal Cancer Screening** | Requirement for Coverage | RCW 48.43.043(1) | Plan must provide coverage for colorectal cancer exams and lab tests consistent with the A and B recommendations of the USPSTF or the CDC. Coverage must be provided: |  |  |
|  | RCW 48.43.043(1)(a)  RCW 48.43.043  (1)(b)(i) | * For any of the colorectal screening exams and tests in the selected recommendations, at a frequency identified therein, as deemed appropriate by the patient's physician after consultation with the patient; and To an enrollee who is:   + At least fifty years old; or |  |  |
|  | (1)(b)(ii) | * + Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations. |  |  |
| Burdensome Requirements Prohibited | RCW 48.43.043(2) | * Plan design must not require patients and providers to meet burdensome criteria or overcome significant obstacles to secure such coverage. Enrollee may not be required to pay an additional deductible or coinsurance for testing greater than a deductible or coinsurance for similar benefits. If the plan does not cover a similar benefit, a deductible or coinsurance may not be set that materially diminishes the value of the colorectal cancer benefit required. |  |  |
| If no in-network provider available | RCW 48.43.043(3)(a) | Issuer is not required to provide for referral to an out-of-network provider, unless the carrier does not have an in-network provider that is appropriate, available and accessible to administer the screening exam. |  |  |
| RCW 48.43.043(3)(b) | * If issuer has no appropriate in-network provider, then out-of-network screening exam services and resulting treatment, if any, must be provided at no additional cost to the enrollee beyond what he/she would pay for in-network services. |  |  |
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| **Congenital Abnormalities** | Requirement for Coverage | RCW 48.46.250(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. |  |  |
|  | RCW 48.46.250(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 issuer. The notification period must be no less than sixty days from the date of birth. |  |  |
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| **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 284-46A-050(3) | Filing must comply with The SERFF Industry Manual, and Washington State SERFF Health and Disability Form Filing General Instructions. |  |  |
| Rates must be filed concurrently with forms. |  |  |
| Examination/  Disapproval  Examination/ Disapproval (Cont’d) | RCW 48.46.060(3)(a) | * 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 48.46.060(3)(b) | * + have any title, heading, or other indication of its provisions which is misleading; |  |  |
| (d) | * + contain unreasonable restrictions on the treatment of patients; |  |  |
| (e) | * + violate any provision of this chapter; or |  |  |
| RCW 48.46.060(3)(f) | * + fail to conform to minimum provisions or standards required by OIC regulation; |  |  |
| RCW 48.46.060(5) | * + No health maintenance organization shall cancel or fail to renew the enrollment on any basis of an enrolled participant or refuse to transfer an enrolled participant from a group to an individual basis for reasons relating solely to age, sex, race, or health status. Nothing contained herein shall prevent cancellation of an agreement with enrolled participants (a) who violate any published policies of the organization which have been approved by the commissioner, or (b) who are entitled to become eligible for Medicare benefits and fail to enroll for a Medicare supplement plan offered by the health maintenance organization and approved by the commissioner, or   + (c) for failure of such enrolled participant to pay the approved charge, including cost-sharing, required under such contract, or (d) for a material breach of the health maintenance agreement. |  |  |
| RCW 48.46.060(4) | * The benefits provided by the contract must be reasonable in relation to the amount charged for the contract. |  |  |
| WAC 284-46A-050(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 48.46.060(6) | No agreement form or amendment to an approved agreement form shall be used unless it is first filed with the commissioner. |  |  |
| WAC 284-46A-050(1)(ii) | * Each form must have a unique identifying number and a way to distinguish it from other versions of the same form. * Forms must be legible and filed in final format displayed in ten-point or larger type. |  |  |
| RCW 48.46.060(2) | * Exceptions, reductions, and limitations must be set forth in the contract either included with the benefit provisions to which they apply, or under an appropriate caption, except that if an exception, reduction, or limitation specifically applies only to a particular benefit, it must be included with the benefit to which it applies. |  |  |
| Injury due to Intoxication or Narcotics | RCW 48.46.580 | The plan cannot exclude services solely because the injury is sustained as a result of the insured being intoxicated or under the influence of a narcotic. |  |  |
| Prohibited Limitations | WAC 284-43-5440(1) | * Contract must specifically explain any uniformly applied limitation on the scope, visit number, or duration of a benefit, and state whether the uniform limitation is subject to adjustment based on the specific treatment requirements of the patient. |  |  |
|  | RCW 48.46.060(3)(d) | * Contract must not unreasonably limit benefits to a specified period of time. (e.g., cannot have a provision that services for a particular condition will be covered only for one year without regard to the amount of the benefits paid or provided.) |  |  |
|  | WAC 284-43-5622(7) | * Contract must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs including, but not limited to, a chronic condition caused by illness or injury, either acquired or congenital. |  |  |
|  | WAC 284-43-5622(9)(a)  (b) | * Plan must not create a risk of biased selection based on health status. * The benefits within an EHB category must not be so limited that the coverage for the category is not a meaningful benefit. |  |  |
| Right to legal or arbitration proceedings | WAC 284-46-015; 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 | Great-West Life & Annuity Ins v. Knudson  Thiringer v. American \Motors Ins. | 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. |  |  |
| No Retrospective denials | RCW 48.43.525(1) | * Plan must not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan’s written policies at the time the care was rendered. |  |  |
|  | RCW 48.46.535 | * When an authorized plan representative approves a claim for an individual prescription, the plan may not later reject that claim. |  |  |
| Cost Sharing Requirement for Native Americans | WAC 284-43-5800(1) | * Plan must not apply cost-sharing requirements to Native Americans purchasing a health benefit plan through the exchange, whose incomes are at or below three hundred percent of federal poverty level. |  |  |
| Reasonable Medical Management | WAC 284-43-5800(3) | * Plan may include reasonable medical management to control costs, including promoting the use of appropriate, high value preventive services, providers and settings.   + Plan must permit waiver of an otherwise applicable copayment for a service that is tied to one setting but not the preferred high-value setting, if the enrollee's provider determines that it would be medically inappropriate to have the service provided in the lower-value setting. Issuer may still apply applicable in-network requirements. |  |  |
| Contracting for Outside Services | RCW 48.43.085 | * Contract must state that the issuer may not prohibit enrollees from freely contracting to obtain any health care services outside the plan on any terms the enrollees choose. |  |  |
| No Annual or Lifetime Dollar Limits | WAC 284-43-5622(10) | * An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those specifically permitted under WAC 284-43-5642, 284-43-5702 and 284-43-5782. |  |  |
| Discretionary Clauses Prohibited  Discretionary Clauses Prohibited  (Cont’d) | RCW 48.46.060(2) | * Contract must not purport to give the HMO or any designee authority to make a decision on the contract, or coverage or claims thereunder, which is final and binding on the enrollee. |  |  |
| RCW 48.46.060(3)(a) | * Contract may not contain a “discretionary clause” that purports to reserve discretion to a carrier or its designees to interpret the contract or decide eligibility for benefits, or requires deference to such interpretations or decisions. |  |  |
| WAC 284-46-015(1)(a) | * Specific prohibited provisions:   + That the carrier's interpretation of the terms of the contract is binding; |  |  |
| WAC 284-46-015(1)(b) | * + That the carrier's decision regarding eligibility or continued receipt of benefits is binding; |  |  |
| WAC 284-46-015(1)(c) | * + That the carrier's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding; |  |  |
| WAC 284-46-015(d) | * + That there is no appeal or judicial remedy from a claim denial; |  |  |
| WAC 284-46-015(1)(e) | * + That deference must be given to the carrier's interpretation of the contract or claim decision; and |  |  |
| WAC 284-46-015(1)(f) | * + That the standard of review of a carrier's interpretation of the contract or claim decision is other than a de novo review. |  |  |
| WAC 284-46-015(2) | * Contract may include provisions that inform enrollees that, as part of its routine operations, the carrier applies the terms of its contracts for making decisions, including determinations regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes. |  |  |
| Mis-representation of EHBs | WAC 284-43-5820 | A health benefit plan issuer must not indicate or imply that a health benefit plan covers essential health benefits unless the plan, policy, or contract covers the essential health benefits in compliance with WAC 284-43-5400 through 284-43-5800. This requirement applies to any health benefit plan offered on or off the Washington health benefit exchange. |  |  |
| Premium Clawback | 45 CFR §147.104  (b)(2)(iii); 45 CFR §155.400 (e)(1)(iv) | * Where an enrollee seeks to renew existing coverage, an issuer may apply the enrollee’s premium payment to that individual’s past debt owed for coverage within the prior 12 months from the same issuer or a different issuer in the same control group before applying the payment toward the renewed enrollment.   *See, also*, 82 FR 18346 (4/18/2017) |  |  |
| The issuer may refuse to effectuate new coverage for failure to pay premiums unless the individual pays all past-due premiums owed to that issuer in order within the prior 12 months to effectuate new coverage from that issuer.  *See, also,* 82 FR 18346, 18349-18350 (4/18/2017). |  |  |
| If an issuer chooses to adopt this premium clawback practice, it must apply this practice uniformly to all employers or individuals in similar circumstances in the applicable market, regardless of health status, and consistent with applicable non-discrimination requirements. *See, also,* 82 FR 18346, 18349 (4/18/2017). |  |  |
| The issuer cannot condition effectuation of new coverage on payment of past due premiums owed to another issuer, or upon payment of past due premiums owed by any individual other than the person contractually responsible for the payment of premiums (e.g., dependents or third parties). *See, also,* 82 FR 18346, 18350 (4/18/2017). |  |  |
| If an issuer chooses to adopt this premium clawback practice, the enrollment or application materials must clearly describe the consequences of non-payment on future enrollment. *See, also,* 82 FR 18346, 18350 (4/18/2017). |  |  |
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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)** | Disclosure of Coordination |  | **If the plan satisfies the following criteria by using the model COB provisions, you may skip the rest of the COB section. If not using the model COB provisions, please review for all COB requirements.** |  |  |
| 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? |  |  |
|  | * Does the contract use the model “plain language description” of COB in WAC 284-51-260, Appendix B? |  |  |
| General | 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)  (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 | • A carrier may not administer COB in a way that reduces total benefits payable below an amount equal to 100% of total allowable expenses. (Note: by its terms, this statute applies to HMOs) |  |  |
| 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. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. |  |  |
| 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. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than this definition. |  |  |
| WAC  284-51-195(12)(a) | * No plan may use COB, or any provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan in Chapter 284-51 WAC. |  |  |
| WAC 284-51-195(12)(b)(i) | * "Plan" includes:   + Group or individual contracts or blanket disability contracts; |  |  |
| (12)(b)(ii) | * + Closed panel plans or other forms of group or individual coverage; |  |  |
| (12)(b)(iii) | * + The medical care components of long-term care contracts, such as skilled nursing care; and |  |  |
| (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; |  |  |
| WAC 284-51-195(12)(c)(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; |  |  |
| WAC 284-51-195(12)(c)(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; |  |  |
| WAC  284-51-195(12)(c)(x) | * + A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; |  |  |
| WAC 284-51-195(12)(c)(x) | * + Automobile insurance policies required by statute to provide medical benefits; |  |  |
| WAC 284-51-195(12)(c)(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 must pay an amount which, together with the payment made by the primary plan, cannot be less than the allowable expense plans 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) | WAC  284-51-205(1)(a) | 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; |  |  |
| WAC  284-51-245 (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) | * + - 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: |  |  |
| (4)(a))(ii)(I) | * + - * Secondary to the plan covering the person as a dependent; and |  |  |
| (4)(a)(ii)(II) | * + - * Primary to the plan covering the person as other than a dependent (e.g., a retired employee); |  |  |
| WAC  284-51-205 (4)(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: |  |  |
| WAC 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: |  |  |
| WAC 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 |  |  |
| WAC 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; |  |  |
| (II) | * + - * + The plan covering the custodial parent's spouse, second; |  |  |
| (III) | * + The plan covering the noncustodial parent, third; and then |  |  |
| (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. |  |  |
| (4)(b)(iii)(c) | * + 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. |  |  |
| (4)(e) | * + 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 |  |  |
| WAC 284-51-205  (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. |  |  |
| Rules for Secondary Plan Payment  Rules for Secondary Plan Payment (Cont’d) | WAC 284-51-230(1) | * + - In determining the amount to be paid by the secondary plan if the plan wishes to coordinate benefits, the secondary plan must pay an amount that, when combined with the amount paid by the primary plan, the total benefits paid by all plans equal one hundred percent of the total allowable expense for that claim. The secondary carrier must not be required to pay an amount in excess of its maximum benefit plus accrued savings. The enrollee must not be responsible for a deductible amount greater than the highest of the two deductibles. |  |  |
| 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:  “Facility of Payment” |  | If the plan provides for COB, it must contain provisions substantially as follows: |  |  |
| WAC 284-51-220 | * + - "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 | * + - "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 your primary plan is, 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. |  |  |
|  |  |  |  |  |  |
| **Dependent Enrollment Requirements**  **Dependent Enrollment Requirements (Cont’d)** | Newborn Coverage (“Erin Act”) | RCW 48.43.115(3)(f) | Coverage for newborns must be no less than the coverage of the child's mother for no less than three weeks (21 days), even if there are separate hospital admissions. |  |  |
| 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); RCW 48.46.490(1)  48.01.180 (3) | * 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. * 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 48.46.490(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  48.46.320 | 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 disability or physical handicap 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 48.46.250(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 48.46.250(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 contractor. The notification period shall be no less than sixty days from the date of birth. |  |  |
| Dependents Under Age 26 | RCW 48.46.325(1) | Plans that cover dependents must have language allowing the member to cover dependents under the age of 26. |  |  |
|  |  |  |  |  |  |
| **Diabetes**  **Diabetes**  **(Cont’d)** | Coverage Requirements  Coverage Requirements  (Cont’d) | RCW  48.46.272(2)(a);  WAC 284-43-5642(1)(d)(iii); WAC 284-43-5642(6)(a)(ii); WAC 284-43-5642(7)(f)ii) | * If the contract provides Pharmacy Benefits, the 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  48.46.272  (2)(b);  WAC 284-43-5642(1)(d)(iii) | * 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.   HMO may restrict patients to seeing only health care providers who have signed participating provider agreements with the HMO or an insuring entity under contract with the health care services contractor. |  |  |
| RCW  48.46.272 (3) | * Benefits may be subject to customary cost sharing for all other similar services or supplies within the policy. |  |  |
| (5) | * Services must be covered when deemed medically necessary. |  |  |
| WAC 284-43-5642(1)(b)(ii) | * Plan must provide routine foot care for diabetic persons. |  |  |
|  |  |  |  |  |  |
| **Disclosures**  **Disclosures**  **(Cont’d)**  **Disclosures**  **(Cont’d)**  **Disclosures**  **(Cont’d)**  **Disclosures**  **(Cont’d)** | List of Disclosure | RCW  48.43.510(3) | * Issuer must provide to all enrollees and prospective enrollees a list of available disclosure items, including: |  |  |
| Items | WAC 284-43-5130(4) | * + Instructions on how to access and request copies in paper and electronic forms, and |  |  |
|  | * + Web site links to the entire health plan disclosure information. |  |  |
| Required Offer of Disclosure Items  Required Offer of Disclosure Items  (Cont’d)  Required Offer of Disclosure Items  (Cont’d) | RCW 48.43.510(1)(g)  WAC 284-43-5130(d) | * Plan must clearly and prominently display an offer to provide the information listed below before purchase or selection. Information must be provided upon request (either by paper or electronic, whichever is requested). * Must be prominently displayed and accessible on the issuer’s website and easily understood by the average plan participant. |  |  |
| RCW 48.43.510(1)  (a) | * + listing of covered benefits, including RX benefits, if any,     - copy of the current formulary, if any is used     - definitions of terms such as generic versus brand name, and     - policies regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits; |  |  |
| RCW 48.43.510(1)  (b) | * + listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based; |  |  |
| 48.43.510(1)  (c) | * + statement of the carrier's policies for protecting the confidentiality of health information; |  |  |
| 48.43.510(1)  (d) | * + statement of the cost of premiums and any enrollee cost-sharing requirements; |  |  |
| 48.43.510(1)  (e) | * + summary explanation of the carrier's review of adverse benefit determinations and grievance processes; |  |  |
| 48.43.510(1)  (f) | * + statement regarding the availability of a point-of-service option, if any, and how the option operates; and |  |  |
| 48.43.510(1)  (g); | * + convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. |  |  |
| RCW 48.43.510(2)(a) | * Contract must contain the following written information or notify the enrollee that he is entitled to it upon request:   + Any documents, instruments, or other information referred to in the medical coverage agreement; |  |  |
| RCW 48.43.510(2)(b) | * + A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether any entity must authorize the referral; |  |  |
| RCW 48.43.510(2)(c) | * + Procedures, if any, that an enrollee must first follow for obtaining prior authorization  for health care services; |  |  |
| RCW 48.43.510(2)(d) | * + A written description of any reimbursement or payment arrangements between the issuer and providers, including capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions; |  |  |
| RCW 48.43.510(2)(e) | * + Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists; |  |  |
| RCW  48.43.510(2)(f) | * + An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan; and |  |  |
| RCW 48.43.510(2)(h) | * + Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how people can access its HEDIS data. |  |  |
| WAC 284-43-7100(1) | * Contract must inform enrollees of their rights to free information, including:   + Access to and copies of all information relevant to a claim. |  |  |
| WAC 284-43-7100(3) | * + The reason for any adverse benefit decision for MH/SUD benefits must be provided with the notification of the adverse benefit decision. |  |  |
| WAC 284-43-7100(2) | * + The criteria, processes, strategies, evidentiary standards and other factors used to |  |  |
|  | * + - Make medical necessity determinations of MH/SUD benefits and |  |  |
|  | * + - Apply an NQTL to medical/surgical and MH/SUD benefits under the plan. |  |  |
| WAC 284-170-200(8) | * + - Issuer must disclose that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of the issuer. The description of referral and authorization practices may be included in the summary of benefits and explanation of coverage. |  |  |
| Description of Provider Tiering | WAC 284-170-330(1) | * If the plan providers or facilities are placed in tiers, and this network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another. |  |  |
| WAC 284-170-330(3) | * The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC [284-43-878](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-878), [284-43-879](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-879), and [284-43-880](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-880). |  |  |
| WAC 284-170-330(6) | An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in plan documents so as to deceive consumers as to issuer rating practices and their effect on available benefits. When a tiered network is used, issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to: |  |  |
| WAC 284-170-330(6)(a) | * The providers and facilities participating in the tiered network; |  |  |
| WAC 284-170-330(6)(b) | * The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility; |  |  |
| WAC 284-170-330(6)(c) | * The potential for providers and facilities to move from one tier to another at any time; and |  |  |
| WAC 284-170-330(6)(d) | * The tier in which each participating provider or facility is assigned. |  |  |
| Prescription Drug | WAC 284-170-470 | If a carrier requires cost-sharing for enrollees receiving an [emergency fill](https://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/2016-08/) as defined in WAC 284-170-470, then issuers must disclose that information to enrollees within their policy forms. A clear statement explaining that members may be eligible to receive an emergency fill for prescription drugs under the circumstances described in WAC 284-170-470 must be disclosed. This disclosure must include the process that members use to obtain an emergency fill, and cost-sharing requirements, if any, for an emergency fill. The applicable WAC also does not limit the fill to one per prescription medication per calendar year. – WAC 284-43-5110(5), WAC 284-43-5170 (1)(c), and WAC 284-170-470(8)(c). |  |  |
|  |  |  |  |  |  |
| **Eligibility**  **Eligibility (Cont’d)**  **Eligibility**  **(Cont’d)**  **Eligibility**  **(Cont’d)**  **Eligibility (Cont’d)**  **Eligibility (Cont’d)**  **Eligibility (Cont’d)** | Collection and Use of  Genetic Information | 42 U.S.C. 300gg-4(a)(6); 45 CFR 148.180(b)(1) | * Plan may not establish rules for eligibility (including continued eligibility) based on genetic information. (Genetic Information Nondiscrimination Act (“GINA”)) |  |  |
| 42 U.S.C. 300gg-4(c)(1); | * Plan may not request or require individuals to undergo genetic testing. 45 CFR §148.180(e)(1) |  |  |
| 42 U.S.C. 300gg-4 (d)(2); | * No genetic information may be required prior to enrollment, in connection with that enrollment. 45 CFR §148.180(f)(2)(i) |  |  |
| 45 CFR 148.180(f)(2)(ii) | * If issuer obtains genetic information incidental to the collection of other information concerning anyone, the collection is not a violation as long as it is not for underwriting purposes. This does not apply to any collection where it is reasonable to anticipate that health information will be received, unless the collection explicitly provides that genetic information should not be provided. |  |  |
|  | 42 U.S.C. 300gg-4 (d)(1) | * Plan may not request, require, or purchase genetic information for underwriting purposes. |  |  |
| Collection and Use of Genetic | 45 CFR §148.180(e)(2) | * + Health care professional providing care may recommend or request the enrollee to have a genetic test. |  |  |
| Information (Cont’d) | 45 CFR §148.180(e)(5) | * + Plan may request, but not require, genetic testing for research purposes under specific conditions. |  |  |
|  | 45 CFR §148.180(e)(4), (e)(5)(iii), and (f)(1)(i) | * Issuer cannot collect genetic information for underwriting purposes, unless medically appropriate:   + If an enrollee seeks a benefit, the issuer may limit or exclude the benefit based on whether is medically appropriate and the determination of whether the benefit is medically appropriate is not for underwriting purposes. Thus, if a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information. |  |  |
|  | 45 CFR 148.180(a) | * “Genetic information” can include: |  |  |
|  | 45 CFR §146.122  (a)(3)(iii)(A) | * + With respect to a pregnant woman (or a family member of the pregnant woman), genetic information of any fetus carried by the pregnant woman; and |  |  |
|  | 45 CFR §146.122  (a)(3)(iii)(B) | * + With respect to an individual (or a family member of the individual) who is utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member; |  |  |
|  | (a)(3)(i)(A) | * + Information about the individual’s genetic tests; |  |  |
|  | (a)(3)(i)(B) | * + Information about the genetic tests of the individual’s family members; |  |  |
|  | (a)(3)(i)(C) | * + Information about the manifestation of a disease or disorder in family members of the individual; and |  |  |
| Collection and Use of  Genetic | (a)(3)(i)(D) | * + Any request for, or receipt of, genetic services or participation in clinical research which includes genetic services, by the individual or any family member of the individual. |  |  |
| Information (Cont’d | §146.122  (a)(3)(D)(ii) | * “Genetic information” does not include information about the sex or age of the individual. |  |  |
|  | 45 CFR 148.180(a) and 45 CFR §146.122(a)(5) | * “Genetic test” means an analysis of DNA, RNA, chromosomes, proteins, or metabolites to detect genotypes, mutations, or chromosomal changes. “Genetic test” does not include analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. E.g., a test for the BRCA1 or BRCA2 variant, or for the genetic variant associated with hereditary colorectal cancer is a genetic test. However, an HIV test, complete blood count, or cholesterol test is not. |  |  |
| Preexisting Conditions | 42 U.S.C. §300gg-3(a)  RCW 48.43.012  45 CFR 148.180 (d)(1) | * Plan may not reject an individual for an individual health benefit plan based upon preexisting conditions of the individual. * Plan may not deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions. * Plan may not include a waiting period for benefits or enrollment due to a preexisting condition. |  |  |
| Special Enrollment Periods – Federal Law  Special Enrollment Periods – Federal Law  (Cont’d) | 42 U.S.C.  §300gg-1(b)(1) | * Plan can use open enrollment periods but must offer Special Enrollment where required. 45 CFR 147.104(b)(3) |  |  |
| 45 C.F.R.  §146.117 (a)(3)(i) | * Plan must offer enrollment to eligible persons regardless of open enrollment requirements (“special enrollment”), in the following situations: |  |  |
| 42 U.S.C.  §300gg-3(f)(1) | * + Employee loses other coverage     - If the employee didn’t enroll during open enrollment because they had other coverage. |  |  |
| 42 U.S.C.  §300gg-3(f)(1)(A) | * + Dependent loses coverage     - During open enrollment, the dependent had other coverage.     - Allow both dependent and employee to enroll, but not any other dependents unless they also have their own special enrollment qualifying event. |  |  |
| 42 U.S.C. §300gg-3 (f)(1)(C)(ii) | * + Employee or any dependent loses other coverage (other than for nonpayment or fraud) due to:     - Divorce or legal separation     - Death of an employee under whose coverage they were a dependent     - Termination or reduction in the number of hours worked     - Discontinuation of employer contributions; or |  |  |
| 42 U.S.C. §300gg-3 (f)(1)(c)(i) | * + - Exhaustion of COBRA continuation coverage |  |  |
| Special Enrollment – On or Off the Exchange  Special Enrollment – On or Off the Exchange  (Cont’d) | WAC 284-43-1100(1) | Issuer must make a special enrollment period of not less than sixty days available to any person who experiences one of the following qualifying events: |  |  |
| WAC 284-43-1100(2)(a) | * Loss of minimum essential coverage, unless the loss is based on the individual’s misrepresentation of a material fact or fraud; |  |  |
| (2)(b) | * The loss of eligibility for Medicaid or a public program providing health benefits; |  |  |
| (2)(c) | * Dissolution of marriage or termination of a domestic partnership; |  |  |
| WAC 284-43-1100(2)(d) | * Permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in the new service area; |  |  |
| WAC 284-43-1100(2)(e) | * Birth, adoption or placement for adoption. For newborns, coverage must be effective from the moment of birth; for those adopted or placed for adoption, coverage must be effective from the date of adoption or placement for adoption, whichever occurs first; |  |  |
| WAC 284-43-1100(2)(f) | * Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; |  |  |
| WAC 284-43-1100(2)(g) | * Coverage is discontinued in a qualified health plan by the health benefit exchange and the three month grace period for continuation of coverage has expired; |  |  |
| WAC 284-43-1100(2)(h) | * Exhaustion of COBRA coverage due to failure of the employer to remit premium; |  |  |
| WAC 284-43-1100(2)(i) | * Loss of COBRA coverage where the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available; |  |  |
| WAC 284-43-1100(2)(j) | * Discontinuation of coverage under the Washington State Health Insurance Pool (WSHIP); |  |  |
| (2)(k) | * Loss of dependent status due to age; or |  |  |
| WAC 284-43-1100(2)(l) | * Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership. |  |  |
| Special Enrollment – Qualified Health Plans  Special Enrollment – Qualified Health Plans  (Cont’d) | WAC 284-43-1120(2)(a) | In addition to the special enrollment qualifying events set forth in [WAC 284-43-1100](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-1100), the following special enrollment opportunities must be made available for individual plans offered on the Exchange:   * For qualified individuals who are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, enrollment in a qualified health plan or change from one qualified health plan to another must be permitted one time per month, without requiring an additional special enrollment triggering event; |  |  |
| WAC 284-43-1120(2)(b) | * Applicant demonstrates to the Exchange that the qualified health plan in which they are enrolled violated a material provision of the coverage contract in relation to the individual; |  |  |
| WAC 284-43-1120(2)(c) | * Applicant lost prior coverage due to errors by the Exchange staff or the U.S. Department of Health and Human Services; |  |  |
| WAC 284-43-1120(2)(d) | * Applicant, or his or her dependent, not previously a citizen, national or lawfully present individual, gains such status. For purposes of this subsection, "dependent" means a dependent as defined in RCW [48.43.005](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.005); |  |  |
| WAC 284-43-1120(2)(e) | * The individual becomes newly eligible or newly ineligible for advance payment of premium tax credits, has a change in eligibility for cost-sharing reductions, or the individual's dependent becomes newly eligible. For purposes of (e) and (f) of this subsection, "dependent" means dependent as defined in 26 C.F.R. 54.9801-2; |  |  |
| WAC 284-43-1120(2)(f) | * The individual or their dependent who is currently enrolled in employer sponsored coverage is determined newly eligible for advance payment of premium tax credit pursuant to the criteria established in 45 C.F.R. 155.420 (d)(6)(iii); |  |  |
| WAC 284-43-1120(2)(g) | * In addition to the special enrollment event in WAC [284-170-1100](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-1100) (2)(d), a change in the individual's residence as the result of a permanent move results in new eligibility for previously unavailable qualified health plans. |  |  |
| Special Enrollment – | WAC 284-43-1140(1) | Special enrollment periods must not be shorter than sixty days from the date of the qualifying event. |  |  |
| Duration, Notice, and Effective Dates | WAC 284-43-1140(2) | The effective date of coverage for those enrolling in an individual health plan through a special enrollment period is the first date of the next month after the premium is received by the issuer, unless one of the following exceptions applies: |  |  |
|  | WAC 284-43-1140(2)(a) | * For those enrolling after the fifteenth of the month, the issuer must begin coverage not later than the first date of the second month after the application is received. Issuers may establish an earlier effective date at their discretion; |  |  |
| Special Enrollment – Duration, Notice, and  Effective Dates | WAC 284-43-1140 (2)(b) | * For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption, as applicable, becomes the first effective date of coverage. The same requirement applies to foster children or children placed for foster care on qualified health plans; |  |  |
| (Cont’d) | WAC 284-43-1140 (2)(c) | * For special enrollment based on marriage or the beginning of a domestic partnership, and for special enrollment based on loss of minimum essential coverage, coverage must begin on the first day of the next month. |  |  |
|  | WAC 284-43-1140(3) | For individual plans offered either on or off the health benefit exchange, an issuer must include detailed information about special enrollment options and rights in its health plan documents provided pursuant to WAC [284-43-5130](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5130), and in the policy, contract or certificate of coverage provided to an employer, plan sponsor or enrollee. The notice must be substantially similar to the model notice provided by the U.S. Department of Health and Human Services. |  |  |
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| **Emergency Medical Services (EHB)**  **Emergency Medical Services (EHB)**  **(Cont’d)**  **Emergency Medical Services (EHB)**  **(Cont’d)**  **Emergency Medical Services (EHB)**  **(Cont’d)**  **Emergency Medical Services (EHB)**  **(Cont’d)** | Required Emergency Services | 42 USC §18021(a)(1)(B) and  (b)(1)(B) | * Plan must cover “emergency medical services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as emergency medical services the care and services related to an emergency medical condition. WAC 284-43-5642(2) |  |  |
| Required Emergency Services (Cont’d) | WAC 284-43-5642(2)(a) | Plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services: |  |  |
| WAC 284-43-5642(2)(a)(i) | * Ambulance transportation to an emergency room and treatment provided as part of the ambulance service; |  |  |
| WAC 284-43-5642(2)(a)(ii) | * Emergency room and department based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition; |  |  |
| WAC 284-43-5642(2)(a)(iii) | * Prescription medications associated with an emergency medical condition, including those purchased in a foreign country. |  |  |
| WAC 284-43-5642  (2)(b,c&d) | Plan may not specifically exclude any services classified to the emergency medical services category or establish visit limitations on services in the emergency medical services category. |  |  |
| RCW 48.43.093; WAC 284-43-5642(2)(d);  WAC 284-170-370 | Plan must include the services necessary to screen and stabilize a covered person, classified to the emergency medical services category.  If plan restricts treatment to services by in-network providers, must include a reasonable provision to allow emergency treatment consistent with the scope of the benefits regularly provided by the contract.  Enrollees must have access to emergency services twenty-four hours per day, seven days per week. |  |  |
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| Definition of “Emergency Services” | 42 U.S.C. §300gg-19a (b) (2)(B)  RCW 48.43.005 (14) | * Plan’s definition of "Emergency services" must be consistent with RCW 48.43.005(14), which states:   “’Emergency Services’ means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3))”. |  |  |
| Definition of “Emergency Medical Condition” | 42 U.S.C.  §300gg-19a(b)(2)(A)  RCW 48.43.005(13)  WAC 284-43-0160(7) | * Plan’s definition of "Emergency medical condition" must be consistent with RCW 48.43.005(13), or WAC 284-43-0160(7) which states:   “’Emergency Medical Condition’ means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy”. |  |  |
| Required Terms of Emergency Services Coverage | RCW  48.43.093 (1)(a) | * Plan must cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. |  |  |
| 42 U.S.C.  §300gg-19a(b)(1)(A) | * + The contract must not require prior authorization of emergency services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. |  |  |
|  | RCW  48.43.093 (1)(a);  42 U.S.C.  §300gg-19a(b)(1)(B-C) | * The plan must cover out-of-network emergency services necessary to screen and stabilize a covered person if a prudent layperson would have reasonably believed that use of an in-network emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider or facility. |  |  |
|  | 45 C.F.R. 147.138(b)(2)  (ii) | * + The issuer must not require prior authorization of emergency services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of an in-network emergency department would result in a delay that would worsen the emergency. |  |  |
|  | 42 USC§300gg-19a(b)(1)(D) | * + Emergency out-of-network coverage must be consistent with scope of regular contract benefits. |  |  |
| Required Terms of Emergency Coverage (Cont’d) | RCW  48.43.093 (1)(c) | * + Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles, and an issuer may impose reasonable differential cost-sharing arrangements for out-of-network emergency services, if such differential between in-network and out-of-network cost-sharing does not exceed fifty dollars. |  |  |
|  | RCW  48.43.093 (1)(c) | * + Differential cost sharing for out-of-network emergency services beyond evaluation and stabilization may not be applied if:     - Due to circumstances beyond the enrollee’s control, the enrollee was unable to go to an in-network emergency department in a timely fashion without serious impairment to their health; or     - A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that they would be unable to go to an in-network emergency department in a timely fashion without serious impairment to their health. |  |  |
| 45 CFR §147.138(b)(3)  (i) | * + - In addition to the in-network cost-sharing, plan can balance bill individual for the excess of out-of-network provider charges, over the minimum amount the plan is required to pay (see below). |  |  |
| 45 CFR §147.138(b)  (3)(i)(A-C) | * + - Plan complies with the above cost-sharing requirements for out-of-network emergency services if it provides coverage at the level of the greatest of these three amounts: (1) the median in-network rate, (2) the usual, customary and reasonable rate (or similar rate determined using the plan or issuer’s general formula for determining payments for out-of-network services, or (3) the Medicare rate. *Note: See regulations for more specifics.* |  |  |
| RCW  48.43.093 (2) | * + - For inpatient admission, the issuer may require notification within a specified time frame or as soon thereafter as medically possible, but no less than twenty-four hours. |  |  |
| RCW 48.43.093 (1)(d) | * + - * The issuer must have someone available 24/7 for preauth of post-evaluation or post-stabilization services |  |  |
| RCW  48.43.093 (2) | * + - The issuer may reserve the right to require transfer of a hospitalized enrollee upon stabilization. |  |  |
| Prescription Drugs | WAC 284-43-5642(2)(a)(iii) | Plan must cover prescription medications associated with an emergency medical condition including those purchased in a foreign country. |  |  |
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| **Every Category of Provider**  **Every Category of Provider (Cont’d)**  **Every Category of Provider (Cont’d)** | Requirements | 42 U.S.C. §300gg-5(a)  *See* [ACA FAQ Part XV](http://www.dol.gov/ebsa/faqs/faq-aca15.html) | * + - Plan and Issuer must not discriminate with respect to participation under the plan against any provider acting within the scope of that provider’s license or certification under applicable State law. (Reimbursement rates may vary based on quality or performance measures.) |  |  |
| RCW  48.43.045 (1)(a)(i);  RCW 48.43.515(1) | Every category of provider must be permitted to provide covered services, if the treatment is within the scope of the provider’s licensure. Each enrollee must have adequate choice among providers. WAC 284-43-9970(2) / WAC 284-170-200(2); WAC 284-43-9975(1) / WAC 284-170-270(1) |  |  |
| WAC 284-170-200(1) | Each health plan’s defined service area must have a comprehensive range of primary, specialty, institutional, and ancillary services available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay. |  |  |
|  | WAC 284-170-200(2) | Each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC 284-170-270 for qualified health plans and qualified stand-alone dental plans under WAC 284-170-310. |  |  |
|  | WAC 284-170-270(1) | Issuers must not exclude any category of providers licensed by the State of Washington who provide health care services or care within the scope of their practice for services covered as essential health benefits. |  |  |
| American Indians/  Alaska Natives | WAC 284-170-200(9) | Issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers. |  |  |
| Allowable Limits | RCW 48.43.045  (1)(a)(ii) | * + - * Providers can be required to conform with carrier standards for cost - Containment, administrative procedures, and provision of cost-effective, clinically effective services. |  |  |
| WAC 284-170-270(2-3) | * + - * Issuers may place reasonable limits on specific services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans must not contain unreasonable limits. |  |  |
| WAC 284-170-270(4) | * + - * Plans may use restricted networks. |  |  |
| WAC 284-170-270 (4)(a) | * + - * Plans that use “gatekeepers” or “Medical Homes” for access to specialists may use them for access to specified categories of providers. |  |  |
| No Separate Benefit | WAC 284-170-270(5) | * + - * Issuers may not offer coverage for services by certain categories of providers solely as a separately-priced optional benefit (e.g., chiropractic care; acupuncture). |  |  |
| Coverage of Osteopath services | RCW 48.46.575 | * + - A health maintenance organization that provides health care services to the general public may not discriminate against a qualified doctor of osteopathic medicine and surgery licensed under chapter [18.57](http://app.leg.wa.gov/RCW/default.aspx?cite=18.57) RCW, who has applied to practice with the health maintenance organization, solely because that practitioner was board certified or eligible under an approved osteopathic certifying board instead of board certified or eligible respectively under an approved medical certifying board. |  |  |
| Coverage of Chiropractic care | RCW 48.43.190 | * Plan must cover chiropractic care on the same basis as other care. * Benefits cannot be denied on the basis that a service is not performed by a physician licensed under Chapter 18.57 or 18.71 RCW. |  |  |
|  |  |
| WAC 284-170-360(3) | * Must provide direct access to a chiropractor without a referral for covered chiropractic benefits, but can restrict this to in-network chiropractors. |  |  |
| Denturist if Dental Covered | RCW 48.46.570  48.43.180 | * If plan 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 Podiatry | RCW 48.46.565 | * Issuer may not refuse to pay for covered services solely because the services were provided by a Podiatrist or Podiatric Surgeon. |  |  |
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| **Experimental or Investigational**  **Treatment**  **Experimental or Investigational**  **Treatment**  **(Cont’d)** | Requirements  Requirements (Cont’d) | WAC 284-46-507(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 284-46-507(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. |  |  |
| WAC 284-46-507(2)(a) | * If the Issuer 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: |  |  |
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| WAC  284-46-507(2)(b) | * + "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." |  |  |
|  | * + "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." |  |  |
| WAC  284-46-507(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. |  |  |
| WAC 284-46-507(3)  WAC 284-43-3110 (1) | * 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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| **Grievance Procedures**  **Grievance Procedures** |  | RCW 48.43.005 (21)  WAC 284-43-0160 (11)  WAC 284-43-4500 | * "Grievance" means a written complaint submitted by or on behalf of an enrollee regarding service delivery issues other than denial of payment for, or nonprovision of, medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. |  |  |
|  | RCW 48.43.530(8) | * Contract must provide a clear explanation of the grievance process.   + Process must be accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance. |  |  |
|  | RCW 48.43.530(9) |  |  |
|  | 48.43.530  (4)(c) | * + Issuer may not require enrollee to file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination. |  |  |
|  | WAC 284-43-4520(3) | * + Grievances are not adverse benefit determinations and do not establish the right to internal or external review of an issuer’s resolution of the grievance. |  |  |
|  |  |  |  |  |  |
| **Guaranteed Issue and Continuity of Coverage**  **Guaranteed Issue and Continuity of Coverage (Cont’d)** | Issuer Must Accept All Residents in Service Area | 45 CFR §147.104(a); RCW 48.46.110(2) | Issuer must accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, religion, national origin, health condition, geographic location, employment status socioeconomic status, the presence of any sensory, mental, or physical handicap, other condition or situation, or actual or perceived status regarding HIV or Hepatitis C. |  |  |
| When Plan May Be Nonrenewed | RCW 48.43.038(1)  45 C.F.R. §147.106 (a) | Plan must contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan.   * A plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. |  |  |
|  | RCW 48.43.038 (2)(a) | * Plan may still be canceled or nonrenewed for:   + Nonpayment of premium; |  |  |
|  |  |
|  | RCW 48.43.038(2)(b) | * + Violation of published policies of the carrier approved by the commissioner; |  |  |
|  | RCW 48.43.038  (2)(c) | * + Covered persons entitled to become eligible for Medicare benefits by reason of age who fail to apply for a Medicare supplement plan or Medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations; |  |  |
| When Plan May Be  Nonrenewed | 48.43.038  (2)(d) | * + Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services; |  |  |
| (Cont’d) | (2)(e) | * + Covered persons committing fraudulent acts as to the carrier; |  |  |
|  | (2)(f) | * + Covered persons who materially breach the health plan; or |  |  |
|  | 48.43.038  (2)(g) | * + Change or implementation of federal or state laws that no longer permit the continued offering of such coverage. |  |  |
| Guaranteed Renewability Not Required When | RCW 48.43.038  (3)(a) | * Guaranteed renewability is not required where:   + An issuer has zero enrollment on a product; |  |  |
|  |  |
| 48.43.038  (3)(b) | * + An issuer withdraws from part or all of a service area due to demonstrated lack of clinical, financial, or administrative capacity; |  |  |
| RCW 48.43.038  (3)(c) | * + Issuer provides a 90 day discontinuation notice to each enrollee, offers each the option to enroll in any of the issuer’s other individual plans, and acts uniformly without regard to any health status-related factor; or |  |  |
| RCW 48.43.038  (3)(d) | * + Issuer discontinues offering all individual health coverage in the state and discontinues all existing individual health plans, if the issuer provides 180 day advance notice to the commissioner and each enrollee. In this case, the carrier may not issue any individual health coverage in Washington for five years from the date of the discontinuation of the last health plan. |  |  |
| RCW 48.43.038  (3)(d) | * + - Issuer is not required to provide notice to the commissioner if it discontinues offering a plan to new applicants, if it does not discontinue coverage of existing enrollees. |  |  |
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| **Hospitalization**  **(EHB)**  **Hospitalization**  **(EHB)**  **(Cont’d)**  **Hospitalization**  **(EHB)**  **(Cont’d)**  **Hospitalization**  **(EHB)**  **(Cont’d)** | Required Hospital-ization Services | 42 USC §18021  (a)(1)(B);  42 USC 18022  (b)(1)(C); WAC 284-43-5642(3) | Plan must cover "hospitalization" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis. |  |  |
| WAC 284-43-5642(3)(a); | Plan must include the following services and classify them as hospitalization services: |  |  |
| WAC 284-43-5642(3)(a)(i) | * Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services; |  |  |
| WAC 284-43-5642(3)(a)(ii) | * Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy; |  |  |
| WAC 284-43-5642(3)(a)(iii) | * Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting; |  |  |
| (3)(a)(iv) | * Dialysis services delivered in a hospital; |  |  |
| WAC 284-43-5642(3)(a)(v) | * Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations; and |  |  |
| WAC 284-43-5642(3)(a)(vi) | * A total of fourteen days of respite care services delivered on an inpatient basis in a hospital or skilled nursing facility. These fourteen days of respite care services may be classified as ambulatory care services or hospitalization services, but not both. |  |  |
| Optional Hospital-ization Services | WAC 284-43-5642(3)(b) | Plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the hospitalization category: |  |  |
| WAC 284-43-5642(3)(b)(i) | * Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category; |  |  |
| WAC 284-43-5642(3)(b)(ii)  RCW 48.46.280 | * Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy; |  |  |
| WAC 284-43-5642(3)(b)(iii) | * The following types of surgery:   + Bariatric surgery and supplies; |  |  |
| WAC 284-43-5642(3)(b)(iii) | * + Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly. |  |  |
| (3)(b)(iv) | * Reversal of sterilizations; and |  |  |
| WAC 284-43-5642(3)(b)(v) | * Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye. |  |  |
| Prohibited limitations on Hospital-ization benefits | WAC 284-43-5642(3)(c)(i) | * Plan may not include a waiting period for transplant services. |  |  |
| 42 U.S.C. 18116, §1557 | * Plan may not exclude coverage for sexual reassignment treatment, surgery or counseling services.   RCW 48.30.300; RCW 49.60.040; WAC 284-43-5642(3)(c)(ii) |  |  |
| Allowable limitations on Hospital-ization benefits | WAC 284-43-5642(3)(d)(i) | Plan may include the following limitations on services in the hospitalization category:   * Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility; |  |  |
| WAC 284-43-5642(3)(d)(ii) | * Thirty inpatient rehabilitation service days per calendar year. For purposes of determining actuarial value, this benefit may be classified to the hospitalization category or to the rehabilitation services category, but not to both. |  |  |
| State benefit requirements classified to the Hospital-ization category  State benefit requirements classified to the Hospitaliz-ation category  (Cont’d) | RCW [48.43.185](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.185);  WAC 284-43-5642(3)(e)(i) | State benefit requirements classified to the hospitalization category are:   * General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia; |  |  |
| RCW 48.46.280; WAC 284-43-5642(3)(e)(ii) | * Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury |  |  |
| RCW 48.46.280 | * 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. |  |  |
| RCW 48.46.530; | Coverage for treatment of temporomandibular joint disorder (WAC 284-43-5642(3)(e)(iii); WAC 284-46-506); and |  |  |
| RCW [48.43.125](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.125); WAC 284-43-5642  (3)(e)(iv) | * **IF** a plan covers care in a long term care facility, carrier must allow enrollee to return to the same long term care facility after hospitalization, as long as the following criteria are met: |  |  |
| RCW 48.13.125 (1)(a) | * + The person's primary care physician determines that the medical care needs of the person can be met at the requested facility; |  |  |
| RCW 48.43.125 (1)(b) | * + The requested facility has all applicable licenses and certifications, and is not under a stop placement order that prevents the person's readmission; |  |  |
| RCW 48.43.125 (1)(c) | * + The requested facility agrees to accept payment from the carrier for covered services at the rate paid to similar facilities that otherwise contract with the carrier to provide such services; and |  |  |
| RCW 48.43.125 (1)(d) | * + The requested facility, with regard to the following, agrees to abide by the standards, terms, and conditions required by the carrier of similar facilities with which the carrier otherwise contracts: (i) Utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting that may be required by the carrier. |  |  |
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| **Laboratory Services (EHB)**  **Laboratory Services (EHB)**  **(Cont’d)** | Required Laboratory Services | 42 USC §18021  (a)(1)(B)  42 USC 18022  (b)(1)(H); WAC 284-43-5642(8) | Plan must cover "laboratory services" in a manner substantially equal to the base-benchmark plan. For purposes of determining actuarial value, an issuer must classify as laboratory services the medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X ray, MRI, CAT scan and PET scans. |  |  |
| WAC 284-43-5642(8)(a)(i) | Plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:   * Laboratory services, supplies and tests, including genetic testing; |  |  |
| WAC 284-43-5642(8)(a)(ii) | * Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging; and |  |  |
| WAC 284-43-5642(8)(a)(iii) | * Blood, blood products, and blood storage, including the services and supplies of a blood bank. |  |  |
| Optional Laboratory Services | WAC 284-43-5642(8)(b) | Plan may, but is not required to, include procurement and storage of personal blood supplies provided by a member of the enrollee's family when this service is not medically indicated. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing the health plan's actuarial value. |  |  |
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| **Maternity and Newborn Services (EHB)**  **Maternity and Newborn Services (EHB)**  **(Cont’d)**  **Maternity and Newborn Services (EHB)**  **(Cont’d)**  **Maternity and Newborn Services (EHB)**  **(Cont’d)**  **Maternity and Newborn Services (EHB)**  **(Cont’d)**  **Maternity and Newborn Services (EHB)**  **(Cont’d)** | Required Maternity and Newborn Services | WAC 284-43-5642(4);  42 USC §18021  (a)(1)(B);  42 USC 18022  (b)(1)(D) | Plan must cover "maternity and newborn services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as maternity and newborn services the medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery and to newborn children. |  |  |
| WAC 284-43-5642(4)(a)(i) | Plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:   * In utero treatment for the fetus; |  |  |
| WAC 284-43-5642(4)(a)(ii) | * Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees; |  |  |
| (4)(a)(iii) | * Nursery services and supplies for newborns, including newly adopted children; |  |  |
| (4)(a)(iv) | * Infertility diagnosis; |  |  |
| (4)(a)(v) | * Prenatal and postnatal care and services, including screening; |  |  |
| WAC 284-43-5642(4)(a)(vi) | * Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and |  |  |
| WAC 284-43-5642(4)(a)(vii) | * Termination of pregnancy. Termination of pregnancy may be included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115. |  |  |
| Optional Maternity and Newborn Services | WAC 284-43-5642(4)(b) | A health benefit plan may, but is not required to, include genetic testing of the child's father as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer covers this benefit, the issuer may not include this benefit in establishing actuarial value for the maternity and newborn category. |  |  |
| Allowable limitations | WAC 284-43-5642(4)(c) | Plan may limit coverage of home birth by a midwife or nurse midwife to low risk pregnancy only. |  |  |
| Requirements for Coverage | 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);  WAC 284-170-350(1)(a) | * Women's health care services must include, but need not be limited to: Maternity care; reproductive health services, gynecological care, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast feeding, complications of pregnancy, general examination, preventive care as medically appropriate and medically appropriate follow-up visits for these services; and any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. |  |  |
| Women’s Direct Access  Women’s Direct Access  (Cont’d) | RCW 48.42.100(4) and (5)(a); WAC 284-170-350(3)(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(4) and (5)(c);WAC 284-170-350(3)(b) | * 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. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to an enrollee and then represents to the enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. |  |  |
| WAC 284-170-350(1)(b) | * + Plan must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, plan must not require all child birth to occur in a hospital attended by a physician, thus preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner, a certified midwife, or a licensed midwife. |  |  |
|  |  |  |
| RCW 48.42.100 | * + Plan must cover medically necessary supplies for a home birth. WAC 284-170-350(2). |  |  |
| WAC 284-170-350(1)(c) | * + Plan must not require notification or prior authorization for women's health care practitioners, providers, and facilities unless such requirements are imposed upon other providers offering similar types of service. E.g.,, plan must not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice for the same or similar service. |  |  |
| WAC 284-170-350(1)(b) | * + Plan must not deny coverage for medically appropriate laboratory, imaging, or diagnostic services, or prescriptions for pharmaceutical or medical supplies, ordered by a directly accessed women's health care practitioner within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner.   + Plan must not require authorization by another type of health care practitioner for these services. For example, if plan would cover a prescription written by the primary care provider, the issuer must cover that prescription if written by the directly accessed women's health care practitioner. |  |  |
| WAC 284-170-350(1)(b) | * Contract must include a written explanation of a woman's right to directly access covered women's health care services, including information regarding any limitations to direct access, including, but not limited to:   + Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and   + The issuer's right to limit coverage to medically necessary and appropriate women's health care services. |  |  |
| WAC 284-170-350(5) | * Plan may not impose cost-sharing for directly accessed women's health care services that is not required for access to primary care providers. |  |  |
| State benefit requirement for Services  State benefit requirement for Services (Cont’d) | RCW 48.43.041; WAC 284-43-5642(4)(d)(i) | * Maternity services must include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services |  |  |
| RCW 48.43.115  (3)(f); WAC 284-43-5642(4)(d)(ii) | * Must provide newborn coverage that is not less than the postnatal coverage for the mother, for no less than three weeks; and |  |  |
| RCW 48.46.375; WAC 284-43-5642(4)(d)(iii) | * Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary. |  |  |
| RCW 48.43.115  (3)(a) | * Plan must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay. These decisions must be based on accepted medical practice. |  |  |
| RCW 48.43.115  (3)(b) | * Plan may not deny covered, eligible services for inpatient, postdelivery care to a mother and her newly born child after a vaginal delivery or a cesarean section delivery that is ordered by the attending provider in consultation with the mother. |  |  |
| RCW 48.43.115(3)  (c) | * At the time of discharge, determination of the type and location of follow-up care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice. |  |  |
| RCW 48.43.115(3)  (d) | * Plan may not deny covered, eligible services for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers, home health agencies licensed under chapter [70.127](http://app.leg.wa.gov/RCW/default.aspx?cite=70.127) RCW, and registered nurses licensed under chapter [18.79](http://app.leg.wa.gov/RCW/default.aspx?cite=18.79) RCW. |  |  |
| RCW 48.43.115(3)(e) | * This section does not require attending providers to authorize care they believe to be medically unnecessary. |  |  |
| Length of Stay | RCW 48.43.115(3) and (5);  (“Erin Act”); 42 USC 300gg-51 | * The plan must provide notice that the health care provider in consultation with the mother will determine the care and length of hospital stay.   + If length of stay guideline is stated it must be no less than: 48-hour normal birth/96 caesarian section birth.   + The plan cannot restrict follow-up care when ordered by the attending provider in consultation with the mother. |  |  |
| Dependent Daughter Coverage | WAC 284-43-5622(1) | * Plan must include maternity coverage and newborn delivery for dependent daughters on the same basis as the EHB-benchmark plan. |  |  |
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| **Medical Necessity**  **Medical Necessity (Cont’d)** | Requirements of Medical Necessity Determination Process  Requirements of Medical Necessity Determination Process (Cont’d) | WAC 284-43-5440(2)(a) | * Contract must specifically explain issuer's medical necessity determination process. |  |  |
| WAC 284-43-5440(2)(b) | * Process must:   + be conducted fairly, and with transparency to enrollees and providers, at a minimum when an enrollee or their representative appeals or seeks review of an adverse benefit determination; |  |  |
| WAC 284-43-5440(2)(c) | * + Include consideration of services that are a logical next step in reasonable care if they are appropriate for the patient; |  |  |
| WAC 284-43-5440(2)(d) | * + Identify the information needed in the decision-making process and incorporate appropriate outcomes within a developmental framework; |  |  |
| WAC 284-43-5440(2)(e) | * + Ensure that when the interpretation of the medical purpose of interventions is part of the medical necessity decision making, the interpretation standard can be explained in writing to an enrollee and providers, and is broad enough to address any of the services encompassed in the ten essential health benefits categories of care; |  |  |
| (2)(f) | * + Comply with inclusion of the ten essential health benefits categories; |  |  |
| WAC 284-43-5440(2)(g) | * + Not discriminate based on age, present or predicted disability, expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity; |  |  |
| WAC 284-43-5440(2)(h) | * + Include consideration of the treating provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee; |  |  |
| WAC 284-43-5440(2)(i) | * + Identify by role who will participate in the issuer's medical necessity decision-making process; and |  |  |
| WAC 284-43-5440(2)(j) | * + Ensure that where medically appropriate, and consistent with the health benefit plan's contract terms, an enrollee is not unreasonably restricted as to the site of service delivery. |  |  |
| WAC 284-43-5440(3) | * Medical necessity determination process may include, but is not limited to, evaluation of the effectiveness and benefit of a service for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including no interventions. Cost effectiveness may be one of but not the sole criteria for determining medical necessity. |  |  |
| WAC 284-43-5440(4) | * Within thirty days of receiving a request, an issuer must furnish its medical necessity criteria for any or all essential health benefit categories to an enrollee or provider. |  |  |
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| **MH/SUD Services, Including Behavioral Health Treatment (EHB)**  **Mental Health and Substance Use Disorder (MH/SUD) Services, Including Behavioral Health Treatment (EHB)**  **(Cont’d)**  **Mental Health and Substance Use Disorder (MH/SUD) Services, Including Behavioral Health Treatment (EHB)**  **(Cont’d)**  **Mental Health and Substance Use Disorder (MH/SUD) Services, Including Behavioral Health Treatment (EHB)**  **(Cont’d)**  **Mental Health and Substance Use Disorder (MH/SUD) Services, Including Behavioral Health Treatment (EHB)**  **(Cont’d)**  **Mental Health and Substance Use Disorder (MH/SUD) Services, Including Behavioral Health Treatment (EHB)**  **(Cont’d)**  **Mental Health and Substance Use Disorder (MH/SUD) Services, Including Behavioral Health Treatment (EHB)**  **(Cont’d)**  **Mental Health and Substance Use Disorder (MH/SUD) Services, Including Behavioral Health Treatment (EHB)**  **(Cont’d)** | Requirement for MH/SUD Coverage | 42 USC §18021  (a)(1)(B);  42 USC 18022(b)(1)(E; WAC 284-43-5642(5) | Plan must cover "mental health and substance use disorder services, including behavioral health treatment" substantially equal to the base-benchmark plan. For determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions. |  |  |
| Required MH/SUD Services | WAC 284-43-5642(5)(a)(i) | Plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:   * Inpatient, residential, and outpatient mental health and substance use disorder treatment, including diagnosis, partial hospital programs or inpatient services; |  |  |
|  |  |  |
|  | (5)(a)(ii) | * Chemical dependency detoxification; |  |  |
|  | (5)(a)(iii) | * Behavioral treatment for a DSM category diagnosis; |  |  |
|  | WAC 284-43-5642(5)(a)(iv) | * Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility; |  |  |
|  | WAC 284-43-5642(5)(a)(v) | * Prescription medication including medications prescribed during an inpatient and residential course of treatment; |  |  |
|  | WAC 284-43-5642(5)(a)(vi) | * Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency; |  |  |
|  | WAC 284-43-5642(5)(b)(ii); Benchmark Plan | * Mental health treatment for the following “V code” diagnoses in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM):* |  |  |
| Required MH/SUD |  | * + medically necessary services for parent-child relational problems for children five years of age or younger, |  |  |
| Services  (Cont’d) |  | * + neglect or abuse of a child for children five years of age or younger, |  |  |
|  |  | * + bereavement for children five years of age or younger, |  |  |
|  | 42 U.S.C. 18116, Section 1557 | * gender dysphoria consistent with 42 U.S.C. 18116, Section 1557, RCW [48.30.300](http://app.leg.wa.gov/RCW/default.aspx?cite=48.30.300), [49.60.040](http://app.leg.wa.gov/RCW/default.aspx?cite=49.60.040) and WAC 284-43-5642(5)(b)(ii); and |  |  |
|  | WAC 284-43-5642(5)(b)(ii); Benchmark Plan | * court-ordered mental health treatment which is medically necessary. |  |  |
| Optional MH/SUD Services | WAC 284-43-5642(5)(b)(i) | Plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the category of mental health and substance use disorder services including behavioral health treatment:   * Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services; |  |  |
| WAC 284-43-5642(5)(b)(ii) | * Mental health treatment for diagnostic codes 302 through 302.9 in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or for "V code" diagnoses except for those listed as required services above; and |  |  |
| (5)(b)(iii) | * Court-ordered mental health treatment which is not medically necessary. |  |  |
| Prohibited Limitations on Mental Health and Substance Use Disorder Services | WAC 284-43-5642(5)(c)  42 U.S.C. Sec. 300gg-26; WAC 284-43-5642(5)(f) | * Plan must provide coverage for mental health services and substance use disorder treatment delivered in a home health setting in parity with medical surgical benefits consistent with state and federal law. * Plan must cover mental health services and substance use disorder treatment that is delivered in parity with medical surgical benefits, consistent with state and federal law. This includes any scope and duration limits imposed on these benefits. |  |  |
| Allowable Limitations | WAC 284-43-5642(5)(d) | Plan may limit court-ordered mental health treatment to only when medically necessary. |  |  |
| State benefit requirements | RCW 48.46.291; | * Plan must provide mental health services. WAC 284-43-5642(5)(e)(i) |  |  |
| 48.46.350; 48.46.355 | * Plan must provide chemical dependency detoxification services. WAC 284-43-5642(5)(e)(ii) |  |  |
| RCW 48.46.292; WAC 284-43-5642(5)(e)(iii) | * Plan must provide, and must waive preauthorization for, services delivered pursuant to involuntary commitment proceedings. |  |  |
| Definitions  Definitions  (Cont’d) | RCW 48.46.291(1) | * Plan must define “Mental Health Services” consistent with RCW 48.46.291:   “Medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the HMO's medical director or designee determines the treatment to be medically necessary.” |  |  |
| WAC 284-43-7010 | * Does the plan define Substance Use Disorder consistent with RCW 48.46.291 and WAC 284-43-7010?   “Substance use disorder includes illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter [69.50](http://app.leg.wa.gov/RCW/default.aspx?cite=69.50) RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).” |  |  |
| Mental Health Parity  Mental Health Parity  (Cont’d)  Mental Health Parity  (Cont’d)  Mental Health Parity  (Cont’d) | P.L. 110-343 | * Plan 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”)) |  |  |
| RCW 48.46.291  (2)(c)(i) | * + The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan.     - Preventive services are excluded from this comparison. |  |  |
| RCW 48.46.291  (2)(c)(i) | * + If the plan 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. |  |  |
| RCW 48.46.291  (2)(c)(i) | * + If the plan has any deductible, it must be for medical, surgical, and mental health – it cannot have a separate deductible for mental health. |  |  |
| RCW  48.46.291  (2)(c)(ii) | * + Prescription drugs intended to treat any MH/SUD disorder must be covered to the same extent, and under the same terms and conditions, as other covered prescription drugs. |  |  |
| RCW 48.46.292 | * No preauthorization is required for mental health treatment rendered by a state hospital if the enrollee or covered dependent is involuntarily committed. |  |  |
| RCW 48.46.291(3) | * Health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002. |  |  |
| 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)& (6)(a) & (b) | * + 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)(b) | * 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 284-43-7020(4); WAC 284-43-7010 | * 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 284-43-7040 | * + 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: |  |  |
| WAC 284-43-7010 (a) | * + - Limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; |  |  |
| (b) | * + - Formulary design; |  |  |
| (c) | * + - For plans with multiple network tiers (such as preferred providers and participating providers), network tier design; |  |  |
| (d) | * + - Standards for provider admission to participate in a network, including reimbursement rates; |  |  |
| (e) | * + - Methods for determining usual, customary, and reasonable charges; |  |  |
| (f) | * + - Use of fail-first policies or step therapy protocols; |  |  |
| (g) | * + - Exclusions based on failure to complete a course of treatment; and |  |  |
| (h) | * + - Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit scope or duration of benefits. |  |  |
| WAC 284-43-7010 | * + A permanent exclusion of all benefits for a particular condition or disorder is not an NQTL; may be allowable if not otherwise prohibited. (See definition of “Treatment Limitations”) |  |  |
| WAC 284-43-7060(2) | * + All health plan standards must comply with the parity requirement. Includes: 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, is there any financial requirement or treatment limitation on MH/SUD benefits that is 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. |  |  |
| 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. |  |  |
| WAC 284-43-7080(4) | * Medically necessary benefits for MH/SUD treatment may not be denied solely because they were court ordered. |  |  |
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| **Neuro-developmental Therapy**  **Neuro-developmental Therapy**  **(Cont’d)** | Requirement to Cover  Requirement to Cover  (Cont’d) | WAC 284-43-5642(10) | Contract must provide benefits for neurodevelopmental therapies. (Washington 2017 Base benchmark Plan subject to RCW 48.46.520(1)) |  |  |
| 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). |  |  |
| WAC 284-43-5622(10)(a)(i): | * + Services covered must include physical, speech, and occupational therapies. |  |  |
| RCW 48.46.520(2) | * + Benefits shall be payable only where the services have been delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where covered services have been rendered by such licensee. |  |  |
| RCW 48.46.520(3) | * + Benefits shall be provided to restore and improve function, and for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service. |  |  |
| * + Benefits must be for medically necessary services. WAC 284-43-5622(10)(b) |  |  |
| WAC 284-43-5622(10) | * + Benefits may not be subject to annual or lifetime dollar limits, but may be subject to visit limits, deductible, cost sharing, and requirements for written treatment plans. |  |  |
| WAC 284-43-5622(7)(b) | * + The contract may not exclude or limit coverage for assessment or testing to determine the amount and type of neurodevelopmental therapy needed. |  |  |
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| **Non-Discrimination** | Language Access | 45 CFR § 92.8(a) and (f)(1)(i) | Contract must include, in a conspicuously visible font size, notice of the following: |  |  |
|  |  | 45 CFR § 92.8(a)(1) | * The carrier does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities; |  |  |
|  |  | 45 CFR § 92.8(a)(2) | * The carrier provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities; |  |  |
|  |  | 45 CFR § 92.8(a)(3) | * The carrier provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency; and |  |  |
|  |  | 45 CFR § 92.8(a)(4) | * How to obtain these aids and services. |  |  |
| **Non-Discrimination (Cont’d)** |  | 45 CFR § 92.8(a)(5) | Contract must identify and provide contact information for the responsible employee designated to coordinate its nondiscrimination efforts, including complaints. |  |  |
|  |  | 45 CFR § 92.8(a)(6) and (7) | Contract must notify enrollee of the availability of the grievance procedure and how to file a grievance, and how to file a discrimination complaint with the federal Office of Civil Rights. |  |  |
|  | Taglines | 45 CFR § 92.8(d)(1) | Contract must include taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States. |  |  |
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| **Pediatric Oral Services (EHB)**  **Pediatric Oral Services (EHB)** | Requirement to Cover Requirement to Cover Pediatric Oral Services  (Cont’d) | 42 USC §1802(a)(1)(B)  42 USC 18022(b)(1)(J) | **ATTENTION: Plans sold on the Exchange CAN NOT contain Pediatric Dental benefits as an embedded set of benefits.**  A health plan sold outside the Exchange may include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. WAC 284-43-5760. |  |  |
| WAC 284-43-5760(1)(a) | Plan must satisfy the requirement in one of two ways:   * The plan includes pediatric dental benefits as an embedded benefit **(issuer must submit the “2017 ALL FILERS Individual EMBEDDED Pediatric Dental EHBs Analyst Checklist” in addition to this checklist);** or |  |  |
| WAC 284-43-5760(1)(b) | * The plan does not have pediatric dental benefits, and the issuer receives reasonable assurance that the applicant has obtained or will obtain pediatric dental benefits through a stand-alone QDP. This reasonable assurance must be received by the issuer within 60 days. |  |  |
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| **Pediatric Vision Services (EHB)**  **Pediatric Vision Services (EHB)**  **(Cont’d)** | Requirement for Coverage | WAC 284-43-5782(1 - 2) | * Plan must cover pediatric vision services as an embedded set of services. |  |  |
| 42 USC §18021  (a)(1)(B) | * + Plan must cover pediatric vision services for enrollees until at least the end of the month in which enrollees turn age nineteen. See, also, 42 USC 18022(b)(1)(J). |  |  |
| Required Services | WAC 284-43-5782(1 – 2) | * Plan must cover the following services in a manner substantially equal to the base benchmark plan and classify them as pediatric vision services: |  |  |
| WAC 284-43-5782(2)(a)  (2)(b) | * + Routine vision screening without cost share. WAC 284-43-5642(9)(b)(iv)(A)   + a comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year; |  |  |
|  |  |  |
|  | WAC 284-43-5782(2)(c) | * + One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular lenses; |  |  |
|  | WAC 284-43-5782(2)(d) | * + One pair of frames every calendar year. Plan may have networks or tiers of frames within the plan design as long as there is a base set of frames to choose from available without cost-sharing; |  |  |
|  | WAC 284-43-5782(2)(e) | * + Contact lenses covered once every calendar year in lieu of the lenses and frame benefits.     - This limitation must be based on the manner in which the lenses must be dispensed; if disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. |  |  |
|  |  | * + - This benefit must include the evaluation, fitting and follow-up care relating to contact lenses. |  |  |
| Required Services  (Cont’d) |  | * + - If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism; |  |  |
|  | WAC 284-43-5782(2)(f) | * + - Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows: |  |  |
|  | (2)(f)(i) | * + - * One comprehensive low vision evaluation every five years; |  |  |
|  | WAC 284-43-5782(2)(f)(ii) | * + - * High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and |  |  |
|  | WAC 284-43-5782(2)(f)(iii) | * + - * Follow-up care of four visits in any five-year period, with prior approval. |  |  |
| Allowed Exclusions | WAC 284-43-5782(3)(a) | The plan may include the following exclusions:   * Visual therapy that is otherwise covered under the medical/surgical benefits of the plan; and |  |  |
|  | (3)(b) | * Ordering two pairs of glasses in lieu of bifocals. |  |  |
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| **PKU**  **(Phenyl-ketonuria) Formula**  **PKU**  **(Cont’d)** |  | RCW 48.46.510;  WAC 284-46-100(2) | * Plan must provide coverage for the formulas necessary for the treatment of phenylketonuria.   + Coverage may be limited to the usual and customary charge for such formulas. |  |  |
|  | WAC 284-46-100(3) | * + Coverage may be subject to deductibles, copayments, coinsurance or other reductions applicable to other benefits. |  |  |
|  | WAC 284-46-100(3) | * + Relating the PKU formula to a special expense benefit, such as a prescription drug benefit, is not acceptable unless it results in the PKU formula benefit being paid at an amount no less than other benefits. |  |  |
|  | WAC 284-46-100(4) | * + Premium charged must be no greater as a result of a family or individual receiving PKU benefits. |  |  |
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| **Prescription Drug Services**  **(EHB)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)**  **Prescription Drug Services (EHB)**  **(Cont’d)** | Required Prescription Drug Services  Required Prescription Drug Services  (Cont’d)  Required Prescription Drug Services  (Cont’d) | 42 USC §18021  (a)(1)(B);  42 USC 18022(b)(1)(F) | Plan must cover "prescription drug services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as prescription drug services medically necessary prescribed drugs, medication and drug therapies.  WAC 284-43-5642(6) |  |  |
| WAC 284-43-5642(6)(a)(i) | Plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as prescription drug services:   * Drugs and medications both generic and brand name, including self-administrable prescription medications, |  |  |
| WAC 284-43-5642(6)(a)(ii) | * Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes; |  |  |
| WAC 284-43-5642(6)(a)(iii); | * All FDA-approved contraceptive methods, and prescription-based sterilization procedures for women with reproductive capacity |  |  |
| WAC 284-43-5150(2)(f) | * + "Prescription contraceptives" include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.); |  |  |
| WAC 284-43-5150(2)(a) | * + Plan must not cover prescription contraceptives on a less favorable basis than other covered prescription drugs and prescription devices. Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services. |  |  |
| WAC 284-43-5150(2)(b) | * + Plan may not impose benefit waiting periods, limitations, or restrictions on prescription contraceptives that are not required or imposed on other covered prescription drugs and prescription devices. |  |  |
| WAC 284-43-5150(2)(d) | * + Issuer may use, and Plan may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception defined above. |  |  |
| WAC 284-43-5150(2)(e) | * + If the plan excludes coverage for nonprescription drugs and devices except for those required by law, it may also exclude coverage for nonprescription contraceptive drugs and devices. |  |  |
| WAC 284-43-5642(6)(a)(iv) | * Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order; and |  |  |
| WAC 284-43-5642(6)(a)(v) | * Medical foods to treat inborn errors of metabolism in accordance with RCW [48.44.440](http://app.leg.wa.gov/RCW/default.aspx?cite=48.44.440), [48.46.510](http://app.leg.wa.gov/RCW/default.aspx?cite=48.46.510), [48.20.520](http://app.leg.wa.gov/RCW/default.aspx?cite=48.20.520), [48.21.300](http://app.leg.wa.gov/RCW/default.aspx?cite=48.21.300), and [48.43.176](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.176). |  |  |
| RCW 48.43.176 (1) | * + Each health benefit plan must offer benefits or coverage for medically necessary elemental formula, regardless of delivery method, when a licensed physician or other health care provider with prescriptive authority diagnoses a patient with an eosinophilic gastrointestinal associated disorder. |  |  |
| WAC 284-43-5060 | * Prescription drug benefit must not be such that it results or can reasonably be expected to result in an unreasonable restriction on the treatment of patients. |  |  |
| WAC 284-43-5060(2) | * + A prescription drug benefit that only covers generic drugs constitutes an unreasonable restriction on the treatment of patients. |  |  |
| WAC 284-43-5060(3) | * + Prescription drug benefit or formulary must not exclude coverage for a nonformulary drug or medication if the only formulary drug available for an enrollee's covered condition is one that the enrollee cannot tolerate or that is not clinically efficacious for the enrollee. |  |  |
| WAC 284-43-5060 | * Plan may restrict prescription drug coverage based on contract or plan terms and conditions that otherwise limit coverage, such as medical necessity. |  |  |
| Sole Available Drug Therapy | WAC 284-43-5060(1) | * Plan must cover all FDA-approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition. |  |  |
| No Unreasonable Restrictions on Treatment | WAC 284-43-5060(4) | * Prescribers may use "Dispense as Written" prescriptions (prescriptions which do not allow substitution of a generic or therapeutic equivalent drug for the drug prescribed), subject to the terms and conditions of the health plan. |  |  |
| Coverage of drugs for “off-label” use |  | * Plan 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)(i) |  |  |
| 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. |  |  |
| Optional Prescription Drug Services | WAC 284-43-5642(6)(b) | Plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services for the prescription drug services category. If an issuer includes these services, the issuer may not include the following benefits in establishing actuarial value for the prescription drug services category: |  |  |
|  |  |
|  | WAC 284-43-5642(6)(b)(i) | * Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and |  |  |
|  | (6)(b)(ii) | * Weight loss drugs. |  |  |
| Allowable limitations  Allowable Limitations (Cont’d) | WAC 284-43-5642(6)(c)(i) | * Prescriptions for self-administrable injectable medication may be limited to thirty day supplies at a time, other than for insulin, which may be offered with more than a thirty day supply. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its health benefit plan; |  |  |
| WAC 284-43-5642(6)(c)(ii) | * Teaching doses of self-administrable injectable medications may be limited to three doses per medication per lifetime. |  |  |
| State benefit requirements  State benefit requirements  (Cont’d) | 48.46.510; 48.43.176; | State benefit requirements classified to the prescription drug services category include:   * Medical foods to treat inborn errors of metabolism (WAC 284-43-5642(6)(d)(i)); |  |  |
| 48.46.272; WAC 284-43-5642(6)(d)(ii) | * Diabetes supplies ordered by the physician (Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary; |  |  |
| 48.46.291; 284-43-5642  (6)(d)(iii) | * Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories. |  |  |
| Formulary | WAC 284-43-5642(6)(e) | * An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark plan formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class. |  |  |
| WAC 284-43-5642(6)(e)(i) | * An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement. |  |  |
| Emergency  Fill | WAC 284-43-5170(1)(c) | * If the carrier charges cost sharing for emergency prescription fills as defined under WAC 284-170-470, contract must include a clear statement explaining consumers may be eligible to receive an emergency fill for prescription drugs and include the process for obtaining an emergency fill and include any cost sharing requirements, for an emergency fill. |  |  |
| Disclosure – Pharmacy Statement | WAC 284-43- 5170(4) | Does the contract or certificate of coverage contain the “Your right to Safe and Effective Pharmacy Services” statement? |  |  |
| Drug Exception / Substitution Process  Drug Exception Process (Cont’d) | 45 CFR 156.122(c) | The Plan must have the following processes in place that allow an enrollee, the enrollee's designee, or the enrollee's prescriber to request and gain access to clinically appropriate drugs not otherwise covered by the plan. |  |  |
| 45 CFR 156.122(c) | If an exception request is granted, the plan must treat the excepted drug(s) as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing under §156.130. WAC 284-43-5110(6) |  |  |
| 45 CFR 156.122  (c)(1)(i) | * Standard exception request.   + Plan must have a process for an enrollee, designee, or prescriber to request a standard review of a decision that a drug is not covered by the plan. WAC 284-43-5080(3). |  |  |
| 45 CFR 156.122  (c)(1)(ii) | * + Plan must make its determination on a standard exception and notify the enrollee (or designee) and the prescriber of its coverage determination no later than 72 hours following receipt of the request. WAC 284-43-5080(3)(b) |  |  |
| 45 CFR 156.122  (c)(1)(iii) | * + A health plan that grants a standard exception request must provide coverage of the non-formulary drug for the duration of the prescription, including refills. WAC 284-43-5080(3)(b) |  |  |
| 45 CFR 156.122  (c)(2)(i) | * Expedited exception request.   + Plan must have a process for an enrollee, the enrollee's designee, or the prescriber to request an expedited review based on exigent circumstances. WAC 284-43-5080(3)(c) |  |  |
| 45 CFR 156.122  (c)(2)(ii) | * + Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. WAC 284-43-5080(3)(c) |  |  |
| 45 CFR 156.122  (c)(2)(iii) | * + Plan must make its determination on an expedited review request and notify the enrollee (or designee) and prescriber of its determination no later than 24 hours following receipt of the request. WAC 284-43-5080(3)(c)(i) |  |  |
| 45 CFR 156.122  (c)(2)(iv) | * + If exception is granted, plan must provide coverage of the non-formulary drug for the duration of the exigency. WAC 284-43-5080(3)(c)(ii) |  |  |
| 45 CFR 156.122  (c)(3)(i) | * External exception request review.   + If the Plan denies a request for a standard exception or an expedited exception, the plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescriber to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. WAC 284-43-5080(6) |  |  |
| 45 CFR 156.122  (c)(3)(ii) | * + Plan must make its determination on the external exception request and notify the enrollee (or designee) and the prescriber of its determination no later than: WAC 284-43-5080(6)(a) |  |  |
|  | * + - 72 hours following its receipt of the request, if the original request was a standard exception request, and |  |  |
|  | * + - no later than 24 hours following its receipt of the request, if the original request was an expedited exception request. |  |  |
| 45 CFR 156.122  (c)(3)(iii) | * If the plan grants an external exception review of a standard exception request, the plan must provide coverage of the non-formulary drug for the duration of the prescription. WAC 284-43-5080(6)(b) |  |  |
| 45 CFR 156.122  (c)(3)(iii) | * If the plan grants an external exception review of an expedited exception request, the plan must provide coverage of the non-formulary drug for the duration of the exigency. WAC 284-43-5080(6)(b) |  |  |
| Drug Utilization Review -  Requirement | WAC 284-43-2020(2) | Each issuer must maintain a documented drug utilization review program. The program must include a method for reviewing and updating criteria. Issuers must make drug review criteria available upon request to a participating provider. |  |  |
| to Maintain  Documented Program | 2020(1)(a) | Nonurgent review request" means any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services, or a renewal of a previously approved request, and is not an urgent care request. |  |  |
|  | 2020(1)(b) | "Urgent care review request" means any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function or, in the opinion of a provider with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. |  |  |
| Requirement | (5)(A)(i) | * For urgent care review requests: |  |  |
| to Maintain  Documented  Drug Utilization | WAC 284-43-2020 (5)(a)(i)(A) | * + Must approve the request within forty-eight hours if the information provided is sufficient to approve the claim and include the authorization number, if a prior authorization number is required, in its approval; |  |  |
| Review  Program  (Cont’d) | WAC 284-43-2020  (5)(a)(i)(B) | * + Must deny the request within forty-eight hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or |  |  |
|  | WAC 284-43-2020 (5)(a)(i)(C) | * + Within twenty-four hours, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination: |  |  |
| Requirement  to Maintain  Documented  Drug Utilization  Review  Program  (Cont’d) | (5)(a)(i)(C)(i) | * + - The issuer must give the provider forty-eight hours to submit the requested information; |  |  |
| WAC 284-43-2020  (5)(a)(i)(C)(ii) | * + - The issuer must then approve or deny the request within forty-eight hours of the receipt of the requested additional information and include the authorization number in its approval; |  |  |
| 2020(5)(a)(ii) | * For nonurgent care review requests: |  |  |
|  | WAC 284-43-2020  (5)(a)(ii)(A) | * + Must approve the request within five calendar days if the information is sufficient to approve the claim and include the authorization number in its approval; |  |  |
|  | WAC 284-43-2020  (5)(a)(ii)(B) | * + Must deny the request within five calendar days if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or |  |  |
|  | WAC 284-43-2020 (5)(a)(ii)(C) | * + Within five calendar days, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination: |  |  |
|  | 2020(5)  (a)(ii)(C)(I) | * + - The issuer must give the provider five calendar days to submit the requested additional information; |  |  |
|  | 2020(5)  (a)(ii)(C)(II) | * + - The issuer must then approve or deny the request within four calendar days of the receipt of the additional information and include the authorization number in its approval. |  |  |
| Publishing Formulary | 45 CFR 156.122  (d)(1) | * Plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure and any restrictions on the manner in which a drug can be obtained. List must be in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, the U.S. Office of Personnel Management, and the general public. |  |  |
|  | 45 CFR 156.122  (d)(1)(i) | * + A formulary drug list is easily accessible when:     - * It can be viewed on the plan's public Web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and |  |  |
|  | (d)(1)(ii) | * + - If an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan. |  |  |
| Access to Prescription Drugs | 45 CFR 156.122  (e)(1) | * Plan must have the following access procedures:   + Plan must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless: |  |  |
| 45 CFR 156.122  (e)(1)(i) | * + - The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or |  |  |
| (e)(1)(ii) | * + - The drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. |  |  |
| 45 CFR 156.122  (e)(2) | * Plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing. |  |  |
| Oral Chemotherapy | RCW 48.46.274  WAC 284-43-5200 | * Plan must provide coverage for prescribed, self- administered anticancer medication on a basis at least comparable to cancer chemotherapy medications administered by a health care provider or facility. |  |  |
| Oral Chemotherapy | 5200(1) | * + Plan may not impose dollar limits, copayments, deductibles or coinsurance requirements on coverage for orally administered anticancer drugs or chemotherapy that are less favorable to an enrollee than those that apply to coverage for anticancer medication or chemotherapy that is administered intravenously or by injection. |  |  |
|  | 5200(2) | * + Issuer may not reclassify an anticancer medication or increase an enrollee's out-of-pocket costs as a method of compliance with these requirements. |  |  |
| Prescription Synchro-nization  Prescription Synchro-nization (Cont’d) | RCW 48.43.096(1) | * Issuer must have a prescription synchronization/coordination policy for the dispensing of prescription drugs to the plan's enrollees. |  |  |
| 48.43.096  (1)(a)  48.43.096  (1)(a)(i)  (1)(a)(ii) | * If an enrollee requests medication synchronization for a new prescription, the health plan must permit filling the drug:   o for less than a one-month supply of the drug if synchronization will require more than a fifteen-day supply of the drug; or  o for more than a one-month supply of the drug if synchronization will require a fifteen-day supply of the drug or less. |  |  |
| 48.43.096  (1)(b) | * The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug subject to coinsurance that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications. |  |  |
| 48.43.096  (1)(c) | * The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug with a copayment that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications by: |  |  |
|  | * + Discounting the copayment rate by fifty percent; |  |  |
|  | * + Discounting the copayment rate based on fifteen-day increments; or |  |  |
|  | * + Any other method that meets the intent of this section and is approved by the OIC. |  |  |
|  | **Note:** In order to have an alternative method approved by OIC, the issuer should submit a request for approval to the Manager of the Health & Disability Forms Unit. The request may be sent by any means, including being submitted on the Supporting Documentation tab as part of the filing seeking to utilize the method. The request must include complete information regarding the proposed alternative method.   * + - If the plan utilizes an alternative method that has already been approved by the OIC, the filing should include this information in its filing cover letter or in a separate document attached to the Supporting Documentation tab. The analyst may request verification of approval from the Manager of the Health and Disability Forms Unit. |  |  |
| 48.43.096(2) | * Upon request of an enrollee, the prescribing provider or pharmacist must: |  |  |
| 48.43.096  (2)(a) | * + Determine that filling or refilling the prescription is in the best interest of the enrollee, taking into account the appropriateness of synchronization for the drug being dispensed; |  |  |
| 48.43.096  (2)(b) | * + Inform the enrollee that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing his or her medications; and |  |  |
| 48.43.096  (2)(c) | * + Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse. |  |  |
| 48.43.096  (3)(a) | * "Medication synchronization" means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. |  |  |
| Pharmacists – Eye Drop Refills  Pharmacists – Eye Drop Refills (Cont’d) | 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 |  |  |
| (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. |  |  |
|  |  |  |  |  |  |
| **Preventive and Wellness**  **Services, Including Chronic Disease Management (EHB)**  **Preventive and Wellness**  **Services, Including Chronic Disease Management (EHB)**  **(Cont’d)**  **Preventive and Wellness**  **Services, Including Chronic Disease Management (EHB)**  **(Cont’d)**  **Preventive and Wellness**  **Services, Including Chronic Disease Management (EHB)**  **(Cont’d)**  **Preventive and Wellness**  **Services, Including Chronic Disease Management (EHB)**  **(Cont’d)** | Definition of Preventive and Wellness Services, Including Chronic Disease Management | 42 USC §18021  (a)(1)(B);  42 USC 18022  (b)(1)(I);  WAC 284-43-5642(9) | Plan must cover "preventive and wellness services, including chronic disease management" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic; services that assist in the multidisciplinary management and treatment of chronic diseases; and services of particular preventative or early identification of disease or illness of value to specific populations, such as women, children and seniors. |  |  |
| Requirements for Preventive and Wellness Services | WAC 284-43-5642(9)(a); WAC 284-43-5800(4) | If the plan does not have in its network a provider who can perform the particular service, then the plan must cover the item or service when performed by an out-of-network provider and must not impose cost-sharing with respect to the item or service. |  |  |
| Requirements for Preventive and Wellness Services  (Cont’d) | WAC 284-43-5642(9)(a) | Plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. If a provider determines that a sex-specific recommended preventive service is medically appropriate for an individual, and the individual otherwise satisfies the coverage requirements, the plan must provide coverage without cost-sharing. |  |  |
|  | WAC 284-43-5642(9)(b)(i) | Plan must include the following services as preventive and wellness services, including chronic disease management:   * Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices; |  |  |
|  | WAC  284-43-5642  (9)(b)(ii)(A) | * Screening and tests for which the U.S. Preventive Services Task Force for Prevention and Chronic Care have issued A and B recommendations on or before the applicable plan year; |  |  |
|  | WAC  284-43-5642  (9)(b)(ii)(B) | * + To the extent not specified in a recommendation or guideline, a plan may rely on the relevant evidence base and reasonable medical management techniques, based on necessity or appropriateness, to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service; |  |  |
|  | WAC 284-43-5642  (9)(b)(iii) | * Services, tests and screening contained in the U.S. Health Resources and Services Administration ("HRSA") Bright Futures guidelines as set forth by the American Academy of Pediatricians; and |  |  |
|  | WAC 284-43-5642  (9)(b)(ii)(a) and (b)(iv) | * Services, tests, screening and supplies recommended in the HRSA women's preventive and wellness services guidelines, including USPSTF A and B recommendations for maternal depression screening. |  |  |
| Requirements for Preventive and Wellness Services  (Cont’d) | 45 C.F.R. 147.130  (a)(1)(i) and (iv) | * + Must cover comprehensive lactation support and counseling, by a trained provider during pregnancy and/ or in the postpartum period, and costs for renting breastfeeding equipment.   (Resources: CCIIO FAQs About Affordable Care Act Implementation Parts XII and XXIX) |  |  |
| WAC  284-43-5642  (9)(b)(iv)(A) | * If the plan covers children under the age of nineteen, or covers dependent children age nineteen or over who are on the plan pursuant to RCW 48.46.320, the plan must provide the child with the full range of recommended preventive services suggested under HRSA guidelines for the child's age group without cost-sharing. Services provided in this regard may be combined in one visit as medically appropriate or may be spread over more than one visit, without incurring cost-sharing, as medically appropriate; and |  |  |
|  | WAC  284-43-5642  (9)(b)(iv)(B) | * A plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive service, including providing multiple prevention and screening services at a single visit or across multiple visits. |  |  |
|  | WAC  284-43-5642  (9)(b)(v) | * Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and |  |  |
|  | (9)(b)(vi) | * Wellness services. |  |  |
| Prohibited Wellness Limitations  Prohibited  Wellness Limitations (Cont’d) | 42 USC 300gg-13 (a) | * Plan may not include cost sharing requirements with respect to the preventive services listed under WAC 284-43-5642(9) (b)(i) through (iv) that are provided in-network. (WAC 284-43-5642(9)(d)) |  |  |
| WAC 284-170-200(12) | * The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW [48.43.005](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.005)(37) and WAC [284-43-5640](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5640)(9) and [284-43-5642](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5642)(9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section. |  |  |
| WAC 284-43-5642(10)(b) | * Plan must cover medically necessary neurodevelopmental therapy for any DSM diagnosis without blanket exclusions. (e.g., Plan may not limit outpatient neurodevelopmental therapy services to person’s age six and under.) |  |  |
| State benefit requirements classified in Preventive and Wellness Services  State benefit requirements classified in Preventive and Wellness Services  (Cont’d) | RCW 48.43.043  (1)(b)(i)  (1)(b)(ii) | State benefit requirements classified in this category are:   * Colorectal cancer screening. WAC 284-43-5642(9)(e)(i)   + For a covered individual who is at least 50 years old;   + Less than 50 and at high risk or very high risk for colorectal cancer. |  |  |
| RCW 48.46.275 | * Mammogram services, both diagnostic and screening to include Tomosynthesis. WAC 284-43-5642(9)(e)(ii), SB 5912 |  |  |
|  | * + Plan can apply standard contract provisions for **diagnostic** mammograms applicable to other benefits such as deductible cost sharing. E.g., may apply deductible and copay requirements; and |  |  |
| RCW 48.46.277(1) | * Prostate cancer screening if delivered upon the recommendation of the patient’s physician, ARNP, or Physician Assistant. WAC 284-43-5642(9)(e)(iii) |  |  |
| WAC 284-43-5622(1) | Some state benefit requirements are limited to those receiving pediatric services, but are classified to other categories for purposes of determining actuarial value. These benefits include: |  |  |
| RCW 48.46.520;  WAC 284-43-5642  (10)(a)(i) | * Neurodevelopmental therapy, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition. This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories; and |  |  |
| RCW 48.46.250; WAC 284-43-5642  (10)(a)(ii) | * Treatment of congenital anomalies in newborn and dependent children. This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories. |  |  |
|  |  |  |  |  |  |
| **Prior Authorization** |  | WAC 284-43-2050(2) | * A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use evidence-based clinical review criteria as outlined in [WAC 284-43-2050](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-2050), which includes a method for reviewing and updating clinical review criteria. * A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. A carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program. |  |  |
|  |  | WAC 284-43-2050(3) | * A prior authorization program must meet standards set forth by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and Accreditation Association for Ambulatory Health Care in addition to the requirements of [WAC 284-43-2050](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-2050) and [WAC 284-43-2060](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-2060). * A prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures. |  |  |
| **Prior Authorization**  **(Cont’d)** | Transparency of Standards and Criteria | RCW 48.43.016(1) | * If the plan imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession, the contract must inform enrollees which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers. |  |  |
|  |  | RCW 48.43.016(3) | * Plan must post on its web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions. |  |  |
|  | Prohibited Practices | RCW 48.43.016(2) | * Plan may not require prior authorization for an initial evaluation and management visit and up to six consecutive treatment visits with a contracted provider in a new episode of care of chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies that meet the standards of medical necessity and are subject to quantitative treatment limits of the health plan.   + Plan may require a referral or prescription for these therapies, other than chiropractic. RCW 48.43.515(5) |  |  |
|  |  | RCW 48.43.016  (6)(a) | * + "New episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment. |  |  |
|  |  | RCW 48.43.016  (6)(b) | * + "Contracting provider" does not include providers employed within an integrated delivery system operated by an HCSC. |  |  |
| **Prior**  **Authorization**  **(Cont’d)** | Issuer must Consult with Licensed Provider in Field Being Reviewed | RCW 48.43.016(4) | * Any provider with whom the issuer consults regarding a decision to deny, limit, or terminate covered services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the provider being reviewed or of a specialty which entails the same or similar covered health care service. |  |  |
|  | No Required Discounts | RCW 48.43.016(5) | * Issuer may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party. |  |  |
|  |  |  |  |  |  |
| **Provider Requirements**  **Provider Requirements (Cont’d)**  **Provider Requirements (Cont’d)** | Access to Primary Care Providers | RCW 48.43.515(2); | Plan must allow enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. WAC 284-170-360(1) |  |  |
| RCW 48.43.515(2); | Plan must allow enrollees to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change. WAC 284-170-360(1)(a) |  |  |
| WAC 284-170-360(2) | * Plan must allow an enrolled child direct access to a pediatrician from a list of in-network pediatricians who are accepting new patients. |  |  |
|  | WAC 284-170-360(2)(a) | * Plan must allow enrollees to change pediatricians at any time, with the change becoming effective not later than the beginning of the month following the enrollee's request for the change. |  |  |
|  | RCW 48.43.515(7) | * Issuer must cover services of a primary care provider whose contract with the plan is being terminated without cause for at least sixty days following notice of termination to the enrollees. |  |  |
| Access to Specialists | RCW 48.43.515(3); | Issuer must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time. WAC 284-170-360(3) |  |  |
|  | RCW 48.43.515(4)  WAC 284-170-200(5) | * Issuer must provide for appropriate and timely referral of enrollees to a choice of in-network specialists if warranted. If the type of specialist needed for a specific condition is not in-network, enrollees must have access to out of network specialist at in-network cost sharing. |  |  |
| Direct Access to Chiropractors | RCW 48.43.515(5) | * Plan must provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic care without prior referral. WAC 284-170-360(4) |  |  |
|  | RCW 48.43.515(5) | * + Plan can restrict coverage to in-network chiropractors and utilize managed care and cost containment techniques and processes. |  |  |
| Second Opinion | RCW 48.43.515(6); | * Contract must explain how to obtain a second opinion consultation. |  |  |
|  |  | * + Enrollee may seek a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice. |  |  |
|  | WAC 284-170-360(5) | * + Plan cannot impose any charge or cost for the second opinion other than the cost imposed for the same service in otherwise similar circumstances. WAC 284-170-360(5) |  |  |
| Hold  Harmless | WAC 284-170-421 | * The plan cannot contain language that conflicts with Provider Agreement requirements, including, provider may not bill enrollee for covered services except for deductible, copayment, or coinsurance. |  |  |
| Definition of “Participating Provider” | RCW 48.46.020(20) | * Plan must define “Participating Provider” consistent with RCW 48.46.020(20): "’Participating provider’ means a provider who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization. |  |  |
|  |  |  |  |  |  |
| **Rehabilitative and Habilitative Services (EHB)**  **Rehabilitative and Habilitative Services (EHB) (Cont’d)**  **Rehabilitative and Habilitative Services (EHB) (Cont’d)**  **Rehabilitative and Habilitative Services (EHB) (Cont’d)** | Required Rehabilitative and Habilitative Services (EHB) | 42 USC §18021  (a)(1)(B)  42 USC 18022  (b)(1)(G);  WAC 284-43-5642(7)(a) | * Plan must cover "rehabilitative and habilitative services" in a manner substantially equal to the base-benchmark plan. * For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled. |  |  |
|  |  |
| WAC 284-43-5642(7)(b)(i) | Plan must include the following services and classify them as rehabilitative services:   * Cochlear implants; |  |  |
| WAC 284-43-5642(7)(b)(ii) | * Inpatient rehabilitation facilities and professional services delivered in those facilities; |  |  |
| WAC 284-43-5642(7)(b)(iii) | * Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes; |  |  |
| WAC 284-43-5642(7)(b)(iv) | * Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatus used to support, align or correct deformities or to improve the function of moving parts; and |  |  |
| WAC 284-43-5642(7)(b)(v) | * Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax. |  |  |
| Optional Rehabilitative and Habilitative Services | WAC 284-43-5642(7)(c)  WAC 284-43- 5642(7)(c)(i) | Plan may, but is not required to, include the following services as part of the EHB-benchmark package. If plan includes these benefits, they cannot be included in establishing AV for this category:   * Off-the-shelf shoe inserts and orthopedic shoes; |  |  |
| (7)(c)(ii) | * Exercise equipment for medically necessary conditions; |  |  |
| WAC 284-43-5642(7)(c)(iii) | * Durable medical equipment that serves solely as a comfort or convenience item; and |  |  |
| (7)(c)(iv) | * Hearing aids other than cochlear implants. |  |  |
| Habilitative Services Definition | WAC 284-43-5642(7)(d) | For purposes of determining a plan's AV, issuer must classify as habilitative services the range of medically necessary health care services and devices designed to assist a person to keep, learn or improve skills and functioning for daily living. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient or outpatient settings. |  |  |
| Requirement for parity between Habilitative and Rehabilitative services | WAC 284-43-5642(7)(d)(i) | As a minimum level of coverage, limitations on habilitative services must be on parity with those for rehabilitative services. Plan may include such limitations only if the limitations take into account the unique needs of the individual, and target measurable and specific treatment goals appropriate for the person's age and physical and mental condition. |  |  |
| WAC 284-43-5642(7)(d)(i) | * **However**, when habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, **the mental health parity requirements apply** and supersede any rehabilitative services parity limitations that would otherwise be permitted. |  |  |
| Requirements for Habilitative Services | WAC 284-43-5642(7)(d)(ii) | * A health benefit plan must not limit an enrollee's access to covered habilitative services on the basis that some, but not all, of the services in a plan of treatment are provided by a public or government program. |  |  |
| WAC 284-43-5642(7)(d)(iii) | * An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function. |  |  |
| WAC 284-43-5642(7)(d)(iv) | * Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device. |  |  |
| WAC 284-43-5642(7)(d)(v) | * Speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services. |  |  |
| WAC 284-43-5642(7)(d)(vi) | * An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements and included in an individual educational plan (IEP). |  |  |
| Allowable Limitations on Rehabilitative and Habilitative Services | WAC 284-43-5642(7)(e)(i) | * Inpatient rehabilitation facilities and professional services delivered in those facilities may be limited to no less than thirty service days per calendar year; and |  |  |
| WAC 284-43-5642(7)(e)(ii) | * Outpatient physical therapy, occupational therapy and speech therapy may be limited to no less than twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes. |  |  |
| State benefit requirements classified to this category | WAC 284-43-5642(7)(f)(i) | State benefit requirements classified to this category include:   * State sales tax for durable medical equipment; and |  |  |
| RCW 48.46.272(2) | * Coverage of diabetic supplies and equipment. WAC 284-43-5642(7)(f)(ii) |  |  |
| Prohibition on limitations of medically necessary coverage for chronic conditions or diseases | WAC 284-43-5642(7)(g) | An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this requirement, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. (e.g., breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy.) Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value. |  |  |
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| **Subrogation** |  | Thiringer v. American  Motors Ins.,  91 WN 2d 215, 588 P.2d 191 (1978) | 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 |  |  |
| • The Contract must not have any provision which would inappropriately require full reimbursement for all medical expenses. |  |  |
|  | Great West Life Annuity Ins v. Knudson | * 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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| **Telemedicine**  **Telemedicine**  **(Cont’d)** | Definition | RCW  48.43.735(8)(g) | * “Telemedicine” means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include audio-only telephone, fax, or email. |  |  |
| Requirements for Coverage  Requirements for Coverage (Cont’d) | RCW  48.43.735(1)(a); WAC 284-43-5622(6) | * Telemedicine or telehealth services are considered a method of accessing services, and are not a separate benefit for purposes of the essential health benefits package. Issuers must provide coverage for a service provided via telemedicine if:   + the service would be covered when provided in person; and |  |  |
|  |  |
| 48.43.735(1)(b) | * + the service is medically necessary; and |  |  |
| (1)(c) | * + the service is an EHB. |  |  |
| RCW  48.43.735(2)(a) | * + If the service is provided through store and forward technology, there must be an associated office visit between the covered person and the referring health care provider. The associated office visit may also occur via telemedicine. |  |  |
| RCW  48.43.735(2)(b) | * + - Reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health plan and health care provider. |  |  |
| Rules for “Originating Sites”  Rules for “Originating Sites”  (Cont’d) | 48.43.735 (3)(a) | * An originating site for a telemedicine health care service includes a:   + Hospital; |  |  |
|  |  |
| (3)(b) | * + Rural health clinic; |  |  |
| (3)(c) | * + Federally qualified health center; |  |  |
| (3)(d) | * + Physician's or other health care provider's office; |  |  |
| (3)(e) | * + Community mental health center; |  |  |
| (3)(f) | * + Skilled nursing facility; or |  |  |
| (3)(g) | * + Home; or |  |  |
| (3)(h) | * + Renal dialysis center, except an independent renal dialysis center. |  |  |
| RCW 48.43.735(4) | * Any originating site may charge a facility fee for infrastructure and preparation of the patient. Reimbursement must be subject to a negotiated agreement between the originating site and the health plan. A distant site or any other site not identified above may not charge a facility fee. |  |  |
| RCW 48.43.735(5) | * Plan may not distinguish between originating sites that are rural and urban in providing this coverage. |  |  |
| RCW 48.43.735(6) | * Coverage of telemedicine may be subject to all terms and conditions of the plan, including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance applicable to the service when provided in person. |  |  |
| RCW 48.43.735(7) | * Plan does not have to pay for originating site professional fees; service that is not covered; or an out-of-network originating site or provider. |  |  |
| 48.43.735  (8)(a) | * "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine; |  |  |
| 48.43.735  (8)(d) | * "Originating site" means the physical location of a patient receiving health care services through telemedicine; |  |  |
| (8)(f) | * "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email. |  |  |
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| **Transgender Services** |  | 42 USC §18116  RCW 48.30.300  Chapter 49.60 RCW | 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. |  |  |
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| **Unfair and Discriminatory Practices**  **Unfair and Discriminatory Practices**  **(Cont’d)**  **Unfair and Discriminatory Practices**  **(Cont’d)**  **Unfair and Discriminatory Practices**  **(Cont’d)**  **Unfair and Discriminatory Practices**  **(Cont’d)** | False Represen-tation Prohibited | RCW 48.46.400;  RCW 48.46.410 | * No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising on behalf of a HMO. 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. |  |  |
| Cost Sharing Levels | WAC 284-43-5800(5)  WAC 284-43-5800(5)(a) | * If plan has cost-sharing structures or tiers for EHBs, they must not be discriminatory.   + Plan must not apply cost-sharing or coverage limitations differently to enrollees with chronic disease or complex underlying medical conditions than to other enrollees, unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs, without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan. |  |  |
|  | WAC 284-43-5800(5)(b) | * Plan must not establish a different cost-sharing structure or tier for a benefit than is applied to the plan in general if the sole type of enrollee who would access that benefit or benefit tier is one with a chronic illness or medical condition. |  |  |
| Discrimination Prohibited | RCW 48.46.370 | * No health maintenance organization may deny coverage to a person solely on account of the presence of any sensory, mental, or physical handicap. Nothing in this section may be construed as limiting a health maintenance organization's authority to deny or otherwise limit coverage to a person when the person because of a medical condition does not meet the essential eligibility requirements established by the health maintenance organization for purposes of determining coverage for any person. |  |  |
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|  | WAC 284-43-5622(9)(c) | * A benefit may not have a discriminatory effect in practice, outcome or purpose in relation to age, present or predicted disability, and expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity or in the application of the federal Mental Health Parity and Addiction Equity Act of 2008. |  |  |
| Discrimination on the basis of a health factor prohibited -  In General  Discrimination on the basis of a health factor prohibited -  In General  (Cont’d) | 45 CFR 147.110(a) | * Individual plans must comply with 45 CFR §146.121 (which is in the CFR section otherwise only applicable to group coverage). |  |  |
| 42 U.S.C.  §300gg-4(a)(6)  45 CFR §146.121  (a)(1) | * + “Health Factor” means, in relation to an individual:     - Health status; |  |  |
| * + - Medical condition (including both physical and mental illnesses), |  |  |
| 45 CFR §144.103 | * *“Medical condition* or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition. |  |  |
|  | * + - Claims Experience |  |  |
|  | * + - Receipt of health care; |  |  |
|  | * + - Medical History; |  |  |
|  | * + - Genetic Information; |  |  |
|  | * + - Evidence of Insurability; or |  |  |
| 45 CFR §146.121  (a)(2) | * + - * “Evidence of Insurability” includes conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities. |  |  |
|  | * + - Disability. |  |  |
| 45 CFR §146.121(a)  (3)  45 CFR §146.117 | * The decision whether health coverage is elected for an individual (including whether the individual enrolls during special enrollment or late enrollment) is not, itself, within the scope of any health factor. However, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible. |  |  |
| Discrimination In Eligibility Rules  Prohibited  Discrimination on the Basis of a Health Factor Prohibited –  In Rules for Eligibility | 42 U.S.C.  §300gg-4 (a)  45 CFR §146.121  (b)(1)(i) | * Prohibited discrimination in rules for eligibility:   + May not have any rule for eligibility (including continued eligibility) of any individual to enroll that discriminates based on any health factor that relates to that individual or a dependent of that individual, subject to the provisions below regarding how this rule applies to benefits, allows establishment of groups of similarly situated individuals, provides for wellness programs, and permits favorable treatment of individuals with adverse health factors. |  |  |
| 45 C.F.R. §146.121  (b)(1)(ii)(A) | * Rules for eligibility include, but are not limited to, rules relating to—    + Enrollment; |  |  |
| (b)(1)(ii)(B) | * + The effective date of coverage; |  |  |
| (b)(1)(ii)(C) | * + Waiting (or affiliation) periods; |  |  |
| (b)(1)(ii)(D) | * + Late and special enrollment; |  |  |
| (b)(1)(ii)(E) | * + Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages); |  |  |
|  | (b)(1)(ii)(F) | * + Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing) |  |  |
|  | (b)(1)(ii)(G) | * + Continued eligibility; and |  |  |
|  | (b)(1)(ii)(H) | * + Terminating coverage (including disenrollment) of any individual. |  |  |
|  | 45 CFR 148.180(b)(1) | Plan may not establish rules for the eligibility (including continued eligibility) of any individual to enroll based on genetic information. |  |  |
| Discrimination on the basis of a health factor prohibited -  In Benefits | 45 CFR  §146.121  (b)(2)(i)(A) | * Prohibited discrimination in benefits:   + General rule: Issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals. |  |  |
| (b)(2)(i)(B) | * + However, benefits that are provided must be uniformly available to all similarly situated individuals. |  |  |
| 45 CFR  §146.121  (b)(2)(i)(B) | * + Any restriction on a benefit must apply uniformly to all similarly situated individuals. Must not be directed at individual participants based on any health factor.     - Issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants based on any health factor of the participants. |  |  |
| 45 CFR  §146.121  (b)(2)(i)(C) | * + Issuer may require the satisfaction of a deductible, or other cost-sharing requirement if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants based on a health factor. |  |  |
| “Source of Injury” exclusions prohibited | 45 CFR §146.121  (b)(2)(iii)(A) | * If a plan generally provides benefits for a type of injury, the issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury. |  |  |
| Discrimination on the basis of  a health factor prohibited –  In premiums or contributions | 42 U.S.C.  §300gg-4 (b)  45 CFR §146.121  (c)(1) | * Issuer may not require a person, as a condition of enrollment or continued enrollment in the plan, to pay a premium or contribution greater than that for a similarly situated enrollee in the plan based on any health factor of the individual or a dependent of the individual. This includes discounts, rebates, payments in kind, and any other premium differential mechanisms. |  |  |
| 45 CFR 148.180(c)(1) | Plan may not adjust premium amount based on genetic information of the enrollee or a family member. |  |  |
| 45 CFR 148.180  (c)(2)(ii) | * + Manifestation of a disease or disorder in one individual also cannot be used as genetic information about other, covered, individuals. |  |  |
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| **Utilization Review** |  | WAC 284-43-2000(2) | * Issuer must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence and to assure that reviews and second opinions are conducted in a timely manner. |  |  |
|  |  |  | * Time frames for Issuer review determination and notification: |  |  |
|  |  | 284-43-2000(6)(b)(i) | * + For immediate request situations, within one business day when the lack of treatment may result in an emergency visit or emergency admission; |  |  |
|  |  | 284-43-2000(6)(b)(ii) | * + For concurrent review requests that are also urgent care review requests, as soon as possible, taking into account the medical exigencies, and no later than twenty-four hours, provided that the request is made at least twenty-four hours prior to the expiration of previously approved period of time or number of treatments; |  |  |
|  |  | 284-43-2000(6)(b)(iii) | * + For urgent care review requests, must approve or deny within forty-eight hours |  |  |
|  |  | 284-43-2000(6)(b)(iv) | * + For nonurgent preservice review requests, including nonurgent concurrent review requests, within five calendar days; |  |  |
| **Utilization Review** |  | 284-43-2000(6)(b)(v) | * + For postservice review requests, within thirty calendar days. |  |  |
| **(Cont’d)** |  | 284-43-2000(6)(b) | * If the review request from the provider is not accompanied by all necessary information, the carrier must tell the provider what additional information is needed and the deadline for its submission |  |  |
|  |  | 284-43-2000(5) | * Issuer must reimburse reasonable costs of medical record duplications for reviews. |  |  |
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| **10-Day Free Look** |  | RCW 48.46.260 | * Contract must state that the enrollee may return the contract to the issuer or the producer through whom it was purchased within ten days of its delivery to the enrollee if he or she is not satisfied with it for any reason. |  |  |
|  |  | * + Issuer must promptly refund any fee paid. |  |  |
|  |  | * + Upon return, the contract shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. |  |  |
|  |  | * + An additional ten percent penalty will be added to any premium refund due which is not paid within thirty days of return of the policy to the issuer or producer. |  |  |