**ANALYST CHECKLIST**

**DISABILITY CARRIER – INDIVIDUAL SHORT TERM PLANS**

Issuer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State Tracker ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL REVIEW REQUIREMENTS**

Authority to Review Contract – RCW 48.18.100

| **Topic** | **Sub Topic** | **Reference** | **Specific Issue** | **Form and page****or section**  | **Additional Information / Comments** |
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| **Alternative to Hospitalization****Alternative to Hospitalization****(Cont’d)**  | RequirementTo cover home care in lieu of hospitalization | WAC 284-96-500(1) | As an alternative to hospitalization or institutionalization and with the intent to cover placement of the enrollee in the most appropriate, cost-effective setting, plan must include substitution of home health care in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter [70.127](http://app.leg.wa.gov/RCW/default.aspx?cite=70.127) RCW, at equal or lesser cost. |  |  |
| WAC 284-96-500(2) | * Such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.
 |  |  |
| Requirement to cover home care in Lieu of Hospitalization (Cont’d) | WAC 284-96-500(3) | * Such substitution must be made only with the consent of the insured and on the recommendation of the insured's attending physician or licensed provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual enrollee.
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| WAC 284-96-500(4) | * May require that home health agencies or similar alternative care providers have written treatment plans which are approved by the enrollee’s attending physician or other licensed provider.
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| WAC 284-96-500(5) | * Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's contract.
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| **Congenital Abnormalities** | Requirement for Coverage | RCW 48.20.430(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 48.20.430(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)****Contract Standards Required (Cont’d)****Contract Standards Required (Cont’d)****Contract Standards Required (Cont’d)****Contract Standards Required (Cont’d)** | Rate and Form Filing Instructions | WAC 284-58-030(3) | Filing must be complete and comply with The SERFF Industry Manual, and Washington State SERFF Health and Disability Form Filing General Instructions. |  |  |
|  | RCW 48.18.110(1)(c) | * The filing must not:
	+ contain any inconsistent, ambiguous, misleading clauses, exceptions, or conditions, which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract;
 |  |  |
| RCW 48.18.110(1)(d) | * + have any title, heading, or other indication of its provisions which is misleading;
 |  |  |
| RCW 48.18.110(2) | * Benefits provided must be reasonable in relation to the premium charged.
 |  |  |
| RCW 48.18.190 | * Policy must contain entire contract.
 |  |  |
| WAC 284-58-030(2) | * All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.
 |  |  |
| RCW 48.21.060 | * Contract must include a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued; that all statements made by the policyholder or by the individuals insured shall in the absence of fraud be deemed representations and not warranties, and that no statement made by any individual insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such individual or to his or her beneficiary, if any.
 |  |  |
| ReinstatementReinstatement (Cont’d) | RCW 48.20.072; RCW 48.21.050 | * There must be a provision as follows:

“REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, must reinstate the policy: PROVIDED, HOWEVER, That if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.” |  |  |
| Notice of ClaimNotice of Claim (Cont’d) | RCW 48.20.082; RCW 48.20.082; RCW 48.21.050(Cont’d) | There must be a provision as follows:NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at . . . . . . . . . (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he or she shall at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.") |  |  |
| Claim FormsClaim Forms(Cont’d) | RCW 48.20.092; RCW 48.21.050 | There must be a provision as follows:CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, the character and the extent of the loss for which claim is made. |  |  |
| Proof of Loss | RCW 48.20.102; RCW 48.21.050 | Contract may not contain a provision less favorable to individual insureds than:PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. |  |  |
| Time of payment of claimsTime of payment (Cont’d) | RCW 48.20.112; RCW 48.21.050 | Contract may not contain a provision less favorable to individual insureds than:TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. |  |  |
| Payment of benefits | RCW 48.21.110 | Contract cannot conflict with the following:* The benefits payable under any group insurance policy must be payable to the employee or other insured member of the group or to the beneficiary designated by him or her, other than the policyholder, employer or the association or any officer thereof as such, subject to provisions of the policy in the event there is no designated beneficiary as to all or any part of any sum payable at the death of the individual insured.
 |  |  |
| * The policy may provide that any hospital, medical, or surgical benefits thereunder may be made payable jointly to the insured employee or member and the person furnishing such hospital, medical, or surgical services.
 |  |  |
| Physical examination and autopsy | RCW 48.21.100 | Contract may provide that the insurer has the right and opportunity to examine the person of the individual insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law. |  |  |
| Legal Actions | RCW 48.20.142; RCWE 48.21.050 | There must be a provision as follows:LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. |  |  |
| Right to legal or arbitration proceedings | Firestone v. Bruch | In the case of controversy arising out of the contract, a subscriber must not be denied the right to have the controversy determined by legal or arbitration proceedings. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) |  |  |
| No unreasonable payment delays | Great-West Life & Annuity Ins v. KnudsonThiringer v. American Motors Ins | • If plan includes a subrogation provision, the provision must clearly notify enrollee of their right to be fully compensated.• Contract must not contain any provision that unreasonably restricts or delays the payment of benefits payable under the contract. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Thiringer v. American Motors, Inc., 91 Wn.2d 215 (1978). |  |  |
| Payment Grace Period RequiredPayment Grace PeriodRequired(Cont’d) | RCW 48.20.062; RCW 48.21.050 | There must be a provision as follows:GRACE PERIOD: A grace period of . . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies, and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.(A policy which contains a cancellation provision may add, at the end of the above provision: "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision: "Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his or her last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted." |  |  |
| RCW 48.21.325 | * When an authorized plan representative approves a claim for an individual prescription, the plan may not later reject that claim.
 |  |  |
| Discretionary Clauses ProhibitedDiscretionary Clauses Prohibited(Cont’d) | RCW 48.18.110(1)(c) | * Plan may not contain any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract.
 |  |  |
| WAC 284-50-321(1) | * No disability insurance policy may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to an insurer, its agents, officers, employees, or designees in interpreting the terms of a policy or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:
 |  |  |
| WAC 284-50-321(1)(a); | * + That the insurer's interpretation of the terms of the policy is binding;
 |  |  |
| WAC 284-50-321(1)(b); | * + That the insurer's decision regarding eligibility or continued receipt of benefits is binding;
 |  |  |
| WAC 284-50-321(1)(c); | * + That the insurer's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;
 |  |  |
| WAC 284-50-321(1)(d); | * + That there is no appeal or judicial remedy from a denial of a claim;
 |  |  |
| WAC 284-50-321(1)(e); | * + That deference must be given to the insurer's interpretation of the contract or claim decision; and
 |  |  |
| WAC 284-50-321(1)(f) | * + That the standard of review of an insurer's interpretation of the policy or claim decision is other than a de novo review.
 |  |  |
| WAC 284-50-321(2) | * Nothing prohibits an insurer from including a provision in a policy that informs an insured that as part of its routine operations the insurer applies the terms of its policies for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.
 |  |  |
| EHB Misrepresen-tation | RCW 48.30.040; 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. |  |  |
| Less than 3-month Maximum Duration | 45 CFR §144.103 | Short term, limited duration insurance must have an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder with or without the issuers consent) that is less than 3 months after the original effective date of the contract. |  |  |
| Renewal, Continuation, or Nonrenewal ProvisionsProvisions(Cont’d) | WAC 284-50-375(1); 45 CFR §144.103 | Contract must include a renewal, continuation, or nonrenewal provision. The language must be consistent with a short-term contract. It must be appropriately captioned, must appear or be prominently referenced on the first page of the policy, and must clearly state the duration of renewability (if any) and the duration of the term of coverage for which the policy is issued and for which it may be renewed (which, altogether, may not exceed 3 months). |  |  |
| 45 CFR §144.103 | Contract and any application materials must display prominently in at least 14 point type the following: “THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.” |  |  |
| Riders or endorsements after issue | WAC 284-50-375(2) | All riders or endorsements added to a policy after date of issue or at reinstatement or renewal which **reduce or eliminate** benefits or coverage in the policy must require signed acceptance by the policyholder, except:* riders or endorsements requested in writing by the policyholder, or
* exercising a specifically reserved right under the policy.
 |  |  |
| WAC 284-50-375(2) | All riders or endorsements added after date of policy issue which **increase benefits** or coverage **AND increase the premium** during the policy term must be agreed to by the insured, except if the increased benefits or coverage is required by law. |  |  |
| WAC 284-50-375(3) | If a separate additional premium is charged for benefits provided in connection with a rider or endorsement, such premium charge must be set forth in the policy. |  |  |
| WAC 284-50-375(4) | A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage. |  |  |
| WAC 284-50-375(5) | If a policy contains any limitations with respect to preexisting conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations." |  |  |
| WAC 284-50-375(7) | All policies, except single premium nonrenewable policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason. |  |  |
|  | WAC 284-50-375(8) | If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage. |  |  |
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| **Coordination of Benefits****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits****(Cont’d)****COB****(Cont’d)** | Disclosure of Coordination |  | **If the answers to both of the following questions is “yes”, you can skip the rest of the COB section. If not, 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?
 |  |  |
| GeneralGeneral(Cont’d) | WAC284-51-200(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. |  |  |
| WAC284-51-200(4)(a) | * Plan cannot have a COB provision that permits it to reduce its benefits on the basis that:

o Another plan exists and the enrollee did not enroll in that plan; |  |  |
| (4)(b) | o A person could have been covered under another plan; or  |  |  |
| (4)(c) | o A person could have elected an option under another plan that pays a higher level of benefits than what he elected.  |  |  |
| WAC 284-51-200(5) | • Plan may not provide that its benefits are "always excess" or "always secondary" except as permitted in Chapter 284-51 WAC.  |  |  |
| RCW 48.21.200(1) | • A carrier may not administer COB in a way that reduces total benefits payable below an amount equal to 100% of total allowable expenses.  |  |  |
| WAC284-51-230(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.  |  |  |
| WAC284-51-195(1) | • When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.  |  |  |
| Time Limit  | WAC284-51-215(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 COBDefinition of “Plan” for purposes of COB(Cont’d)Definition of Plan for purposes of COB(Cont’d) | WAC284-51-195(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.
 |  |  |
| WAC284-51-195(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.
 |  |  |
| WAC284-51-195(12)(a) | * Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in WAC 284-51-195(12).
 |  |  |
| WAC 284-51-195(12)(b)(i) | * "Plan" includes:
	+ Group or individual contracts or blanket disability contracts;
 |  |  |
| WAC 284-51-195(12)(b)(ii) | * + Closed panel plans or other forms of group or individual coverage;
 |  |  |
| WAC 284-51-195(12)(b)(iii) | * + The medical care components of long-term care contracts, such as skilled nursing care; and
 |  |  |
| WAC 284-51-195(12)(b)(iv) | * + Medicare or other governmental benefits, as permitted by law. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.
 |  |  |
| WAC 284-51-195(12)(c)(i) | * “Plan” does not include:
	+ Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
 |  |  |
| (ii) | * + Accident only coverage;
 |  |  |
| (iii) | * + Specified disease or specified accident coverage;
 |  |  |
| (iv) | * + Limited benefit health coverage, as defined in WAC 284-50-370;
 |  |  |
| 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;
 |  |  |
| (ix) | * + A state plan under Medicaid;
 |  |  |
| WAC284-51-195(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)(xi) | * + Automobile insurance policies required by statute to provide medical benefits;
	+ 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 | WAC284-51-200(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.
 |  |  |
|  | WAC284-51-195(5) | * "Closed panel plan" means a plan that provides benefits in the form of services primarily through providers employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
 |  |  |
|  | WAC 284-51-195(1) | * The definition of “allowable expense” should be clear that when coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the allowable expense the secondary plan would have paid if it was primary. A secondary plan must not be required to pay an amount in excess of its maximum benefit plus accrued savings.
 |  |  |
| Rules for Coordination of BenefitsRules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d) | WAC284-51-205(1)(a) |

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| 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.
 |  |  |
| WAC284-51-205 (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.
 |  |  |
| WAC284-51-205 (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.
 |  |  |
| WAC284-51-205 (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.
 |  |  |
| WAC284-51-205 (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.
 |  |  |
| WAC284-51-245 (2)(a) | * + A plan with order of benefit determination rules that comply with the WAC rules (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary", or that uses order of benefit determination rules inconsistent with the WAC rules (noncomplying plan) on the following basis:
 |  |  |
| (2)(a)(i) | * + - If the complying plan is the primary plan, it must provide its benefits first;
 |  |  |
| (2)(a)(ii) | * + - If the complying plan is the secondary plan under Chapter 284-51 WAC, it must provide its benefits first, but the amount of benefits payable must be determined as if the complying plan were the secondary plan. In this situation, the payment is the limit of the complying plan's liability; and
 |  |  |
| WAC284-51-245 (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.
 |  |  |
| WAC284-51-245 (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.
 |  |  |
| WAC284-51-245 (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.
 |  |  |
| WAC284-51-205 (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:
 |  |  |
| WAC284-51-205 (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.
 |  |  |
| WAC284-51-205 (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:
 |  |  |
|  | * + - * Secondary to the plan covering the person as a dependent; and
 |  |  |
|  | * + - * Primary to the plan covering the person as other than a dependent (e.g., a retired employee);
 |  |  |
|  | 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.  |  |  |
| WAC284-51-205(4)(b) | * + Dependent child covered under more than one plan.
		- Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits as follows:
 |  |  |
| 284-51-205(4)(b)(i) | * + - For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 |  |  |
| 284-51-205 (4)(b)(i)(A) | * + - * The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 |  |  |
| 284-51-205 (4)(b)(i)(B) | * + - * If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
 |  |  |
| WAC284-51-205 (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:
 |  |  |
| WAC284-51-205 (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;
 |  |  |
| WAC284-51-205 (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;
 |  |  |
| WAC284-51-205 (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;
 |  |  |
| WAC284-51-205 (4)(b)(ii)(D) | * + - * If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the dependent child, the above provisions for parents married or living together determine the order of benefits; or
 |  |  |
| WAC 284-51-205 (4)(b)(ii)(E) | * + - * If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows:
 |  |  |
| (4)(b)(ii)(E)(I) | * + - * + The plan covering the custodial parent, first;
 |  |  |
| (4)(b)(ii)(E)(II) | * + - * + The plan covering the custodial parent's spouse, second;
 |  |  |
| (4)(b)(ii)(E)(III) | * + The plan covering the noncustodial parent, third; and then
 |  |  |
| (4)(b)(ii)(E)(IV) | * + - * + The plan covering the noncustodial parent's spouse, last.
 |  |  |
| WAC284-51-205(4)(b)(iii) | * + - For a dependent child covered under more than one plan of individuals who are not the child’s parents, the order of benefits is determined as if they were the parents of the child.
 |  |  |
|  | * + Active employee or retired or laid-off employee.
 |  |  |
| WAC284-51-205(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
 |  |  |
| WAC284-51-205(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.
 |  |  |
| WAC284-51-205(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.
 |  |  |
|  |

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| --- |
| * Longer or shorter length of coverage
 |

 |  |  |
| WAC284-51-205(4)(e)(i) | * + If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
 |  |  |
| WAC 284-51-205(4)(e)(ii) | * + - To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the enrollee was eligible under the second plan within twenty-four hours after coverage under the first plan ended.
 |  |  |
|  | * + The start of a new plan does not include:
 |  |  |
| (4)(e)(iii)(A) | * + - A change in the amount or scope of a plan's benefits;
 |  |  |
| (4)(e)(iii)(B) | * + - A change in the entity that pays, provides or administers the plan's benefits; or
 |  |  |
| (4)(e)(iii)(C) | * + - A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
 |  |  |
| WAC 284-51-205(4)(e)(iv) | * + The length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date to determine the length of time his coverage under the present plan has been in force.
 |  |  |
| WAC284-51-205(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 PaymentRules 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:
 |  |  |
| WAC284-51-230(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.
 |  |  |
| WAC284-51-230(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.
 |  |  |
| WAC284-51-230(4) | * + - When a plan is secondary, it may reduce its benefits so the total benefits provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate and record its savings from the amount it would have paid had it been primary, and must use these savings to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period, so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.
 |  |  |
| Required Provisions |  | If the plan provides for COB, it must contain provisions substantially as follows: |  |  |
| “Facility of Payment” | WAC 284-51-220 | * + - "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 284-51-235WAC 284-51-235 (Cont’d) | * + - The plan must include the following statement in the enrollee contract or booklet provided to covered persons:

"If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days. CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage."  |  |  |
| If Plans Cannot Agree Which is Primary | WAC 284-51-245(4) | If the plans cannot agree on the order of benefits within thirty calendar days after they have received the information needed to pay the claim, they must immediately pay the claim in equal shares and determine their relative liabilities following payment. No plan is required to pay more than it would have paid had it been the primary plan. |  |  |
|  |  |  |  |  |  |
| **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 48.21.280(1) | * Coverage for dependent children placed for adoption must be provided under the same terms and conditions as apply to natural, dependent children, whether or not the adoption has become final.
 |  |  |
|  |  |
| RCW 48.01.180(3) | * Contract may not restrict coverage of any dependent child adopted by, or placed for adoption with, an enrollee solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the enrollee is eligible for coverage under the plan.
 |  |  |
| RCW 48.21.280(2) | * If payment of an additional premium is required to provide coverage for the child, the contract may require notification of placement and payment of the required premium. The notification period shall be no less than sixty days from the date of placement.
 |  |  |
| Disabled Child Over Age Limit | RCW 48.21.150 | If the contract states that coverage of a dependent child will terminate upon attainment of the limiting age for dependent children, the contract must also state that coverage of a dependent child will not be terminated while the child is and continues to be **both** (1) incapable of self-sustaining employment by reason of developmental 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 48.21.155(1) | * If plan covers dependent children of the enrollee, it must provide coverage for newborn infants of the enrollee from and after the moment of birth. Must include coverage for congenital anomalies of such infant children from the moment of birth.
 |  |  |
|  | RCW 48.21.155(2) | * If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the contractor. The notification period shall be no less than sixty days from the date of birth.
 |  |  |
| Dependents Under Age 26 | RCW 48.21.157 | Plans that cover dependents must have language allowing the member to cover dependents under the age of 26. |  |  |
|  |  |  |  |  |  |
| **Diabetes****Diabetes****(Cont’d)** | Coverage RequirementsCoverage Requirements (Cont’d) | RCW 48.21.143(1)(a) and (2) | * If the contract provides Pharmacy Benefits, Contract must provide appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, for all subscribers diagnosed “Insulin using”, “Non-insulin using”, and “elevated blood glucose induced by pregnancy. This must include:
 |  |  |
| RCW 48.21.143 (2)(a) | * + 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.
 |  |  |
| RCW48.21.143(2)(b) | * Whether or not the contract provides Pharmacy Benefits, contract must provide:
	+ outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by providers with expertise in diabetes.
 |  |  |
| RCW48.21.143 (2)(b) | * + Issuer may restrict patients to seeing only health care providers who have signed participating provider agreements with the Issuer or an insuring entity under contract with the health care services contractor.
 |  |  |
| RCW48.21.143 (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.
 |  |  |
|  |  |  |  |  |  |
| **Disclosures****Disclosures****(Cont’d)****Disclosures****(Cont’d)** | Disclosure of Limitations on Access | 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(2) | * 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.
 |  |  |
| Short Term Non- Qualifying- Coverage disclosure | 45 CFR §144.103 | Contract must display the following notice prominently in the contract and in any application materials provided inconnection with enrollment (in at least 14 point type): “THIS ISNOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLECARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.” |  |  |
|  |  |  |  |  |  |
| **Preexisting Conditions** | No restrictions based on past mastectomy or lumpectomy | RCW 48.21.235 | * Issuer may not refuse to issue, cancel, or decline to renew any contract solely because of a mastectomy or lumpectomy performed on the insured or prospective insured more than 5 years previously.
 |  |  |
| RCW 48.21.235 | * Issuer may not restrict, modify, exclude, increase, or reduce the amounts of benefits payable or any term, rate, condition, or type of coverage solely on the basis of a mastectomy or lumpectomy performed on the insured more than 5 years previously.
 |  |  |
|  |  |  |  |  |  |
| **Emergency Services****Emergency Services (Cont’d)****Emergency Services (Cont’d)****Emergency Services (Cont’d)****Emergency Services (Cont’d)** | Requirement to Cover | RCW 48.43.093(1)(a) | Plan must cover emergency services necessary to screen and stabilize enrollee if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. * Must not require prior authorization of emergency services provided prior to the point of stabilization.
 |  |  |
|  |  | * If care obtained from a nonparticipating hospital emergency department, plan must cover, and must not require prior authorization for, emergency services necessary to screen and stabilize covered person if a prudent layperson would have reasonably believed that use of a participating hospital 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.
 |  |  |
| No withdrawal of authorization after services provided | RCW 48.43.093RCW 48.43.093 (1)(b)Cont’d) | * If an authorized representative of the carrier authorizes coverage of emergency services, the carrier must not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the enrollee's health condition made by the provider of emergency services.
 |  |  |
| May charge cost-sharing and out-of-network differential up to $50 | RCW 48.43.093(1)(c) | * Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles, and a health carrier may impose reasonable differential cost-sharing arrangements for emergency services rendered by nonparticipating providers, if such differential between cost-sharing amounts applied to emergency services rendered by participating provider versus nonparticipating provider does not exceed fifty dollars.
 |  |  |
| No differential cost-sharing if… | RCW 48.43.093(1)(c) | * + Differential cost sharing for emergency services may not be applied when enrollee goes to a nonparticipating hospital emergency department rather than a participating hospital emergency department when the health carrier requires preauthorization for postevaluation or poststabilization emergency services if:
 |  |  |
|  | RCW 48.43.093(1)(c)(i) | * + - Due to circumstances beyond the enrollee's control, he or she was unable to go to a participating hospital emergency department in a timely fashion without serious impairment to their health; or
 |  |  |
|  | RCW 48.43.093(1)(c)(ii) | * + - A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital emergency department in a timely fashion without serious impairment to their health.
 |  |  |
| Preauth for Post-evaluation or post-stabilization Services | RCW 48.43.093(1)(d) | If plan requires preauthorization for postevaluation or poststabilization services, plan shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for postevaluation or poststabilization services to be covered, the provider or facility must make a documented good faith effort to contact the plan within thirty minutes of stabilization, if the enrollee needs to be stabilized. The plan's authorized representative must respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the plan to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary postevaluation and poststabilization services, unless the plan documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request. |  |  |
| If Plan and Provider cannot agree on Preauth | RCW 48.43.093(1)(e) | Plan must immediately arrange for an alternative plan of treatment for the enrollee if a nonparticipating emergency provider and the plan cannot reach an agreement on which services are necessary beyond those immediately necessary to stabilize the covered person consistent with state and federal laws. |  |  |
| Plan may require other conditions  | RCW 48.43.093(2) | Carrier may require notification within a time frame specified in the contract for inpatient admission or as soon thereafter as medically possible but no less than twenty-four hours. Plan may reserve the right to require transfer of a hospitalized covered person upon stabilization. Follow-up care that is a direct result of the emergency must be obtained in accordance with the plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services. |  |  |
| 24/7 access  | WAC 284-170-370 | Enrollees must have access to emergency services twenty-four hours per day, seven days per week. |  |  |
| Definition of “Emergency Services” | 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 42 USC 300gg-19a(b)(2)(A), RCW 48.43.005(13), and 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”. |  |  |
|  |  |  |  |  |  |
| **Every Category of Provider****Every Category of Provider (Cont’d)** |  | 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 284-170-200(2); 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. |  |  |
| 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).
 |  |  |
| Services by certain providers | RCW 48.21.141RCW 48.21.130 | * + - Contract must cover services performed by a Registered Nurse, Advanced Registered Nurse Practitioner, or podiatrist if:
 |  |  |
| * + - * the service is within the scope of the provider’s license, and
 |  |  |
| * + - * The contract would have covered the service if it had been performed by a physician licensed under Chapter 18.71 RCW.
 |  |  |
| Coverage of Chiropractic care | RCW 48.21.142 | * Benefits for services provided by a chiropractor cannot be denied on the basis that a service is not performed by a physician licensed under Chapter 18.57 or 18.71 RCW.
 |  |  |
|  |  |
| WAC 284-170-360(3) | * If plan covers chiropractic care, 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 48.21.148;RCW 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.
 |  |  |
|  |  |  |  |  |  |
| **Experimental or Investigational****Treatment****Experimental or Investigational Treatment (Cont’d)****Experimental or Investigational Treatment (Cont’d)** | Required definition | WAC 284-96-015(1) | * If the contract includes exclusion, reduction or limitation for services that are experimental or investigational, contract must include a definition of Experimental and Investigational services.
 |  |  |
| WAC 284-96-015 (2) | * + The definition must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational.
 |  |  |
| Disclosure of criteria for determining “experimental” or “investi-gational” | WAC 284-96-015(2) | * + - If the carrier or an affiliated entity is the authority making the determination, it must state the criteria it will utilize to make the determination. This requirement may be satisfied by using one or more of the following statements, or other similar statements:
 |  |  |
| WAC 284-96-015(2)(a) | * + - * "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."
 |  |  |
| WAC284-96-015(2)(b) | * + - * "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."
 |  |  |
| Supporting documentation | WAC284-96-015(2)(b) | * + The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.
 |  |  |
| Time frames for denial | WAC 284-96-015(3) | * Whether the claim or request for preauthorization is made in writing or through other claim presentation or preauthorization procedures set out in the contract, any denial because of an experimental or investigational exclusion or limitation, must be done in writing within twenty working days of receipt of a fully documented request. The issuer may extend the review period beyond twenty days only with the informed written consent of the enrollee.
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|  |  |  |  |  |  |
| **Fraud Statement (Application)** |  | RCW 48.135.080 | All outside market applications must contain a statement similar to the following: “It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.” This includes applications for plans normally sold on the Exchange which are purchased directly from the issuer. |  |  |
|  |  |  |  |  |  |
| **Mandated Benefits** | Re-constructive Surgery following Mastectomy | RCW 48.21.230(1) | * Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury
 |  |  |
| RCW 48.20.395(2) | * Coverage for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.
 |  |  |
| Gender Reassignment | 42 U.S.C. 18116 | * Plan may not exclude coverage for sexual reassignment treatment, surgery or counseling services.

45 CFR §156.200(e); 45 CFR §92.206 and 92.207 (especially section (b)(4)); RCW 48.30.300; RCW 49.60.040 |  |  |
|  |  |  |  |  |  |
| **Maternity and Newborn Coverage****Maternity and Newborn Coverage (Cont’d)****Maternity and Newborn Coverage (Cont’d)****Maternity and Newborn Coverage (Cont’d)****Maternity and Newborn Coverage (Cont’d)** | Women’s Health Care Practitioners Must Include | RCW 48.42.100(2) | * Health care practitioners that provide women's health care services must include, but need not be limited to:
 |  |  |
|  | * + Any generally recognized medical specialty of practitioners licensed under chapter [18.57](http://app.leg.wa.gov/RCW/default.aspx?cite=18.57) or [18.71](http://app.leg.wa.gov/RCW/default.aspx?cite=18.71) RCW who provides women's health care services; practitioners licensed under chapters [18.57A](http://app.leg.wa.gov/RCW/default.aspx?cite=18.57A) and [18.71A](http://app.leg.wa.gov/RCW/default.aspx?cite=18.71A) RCW when providing women's health care services;
 |  |  |
|  | * + midwives licensed under chapter [18.50](http://app.leg.wa.gov/RCW/default.aspx?cite=18.50) RCW; and
 |  |  |
|  | * + advanced registered nurse practitioner specialists in women's health and midwifery under chapter [18.79](http://app.leg.wa.gov/RCW/default.aspx?cite=18.79) RCW.
 |  |  |
| RCW 48.42.100(3); 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 AccessWomen’s Direct Access(Cont’d)Women’s Direct Access(Cont’d)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.
		- Plan must cover medically necessary supplies for a home birth.
 |  |  |
| RCW 48.42.100; WAC 284-170-350(1)(b) |  |  |
| 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(2) | * + 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(4) | * 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:
 |  |  |
| WAC 284-170-350(4)(a) | * + 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.
 |  |  |
| RCW 48.43.115(3)(f) | * Plan must provide newborn coverage that is not less than the postnatal coverage for the mother, for no less than three weeks; and
 |  |  |
| 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) (“Erin Act”); 45 CFR §146.130) | * 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.
 |  |  |
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| **Mental Health and Substance Use Disorder Services****Mental Health and Substance Use Disorder Services****(Cont’d)****Mental Health and Substance Use Disorder Services****(Cont’d)****Mental Health and Substance Use Disorder Services (Cont’d)****Mental Health and Substance Use Disorder Services (Cont’d** | Benefit Mandate | RCW 48.21.242 | * Plan must provide mental health services.
 |  |  |
| Definitions | RCW 48.20.580(1) | * Plan must define “Mental Health Services” consistent with RCW 48.20.580(1):

 “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 health care service contractor's medical director or designee determines the treatment to be medically necessary.” |  |  |
| No “Blanket Limitations” | O.S.T. v. Regence BlueShield, | * Must provide benefits for mental health diagnoses (Diagnoses listed in the DSM) without any “blanket limitations” (e.g., age six and under) O.S.T. v. Regence BlueShield, No. 88940-6 (WN October 9, 2014).
 |  |  |
| Mental Health Parity Requirement | 42 USC §300gg-26; RCW 48.21.241 | * 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 48.21.241(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 plan.
 |  |  |
| RCW 48.21.241(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 48.21.241(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 48.21.241(2)(c)(i) | * + 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 48.21.241(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.
 |  |  |
| Mental Health Parity AnalysisMental Health Parity Analysis (Cont’d)Mental Health Parity Analysis (Cont’d) | WAC 284-43-7020(2) | * + 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) | * 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) | * 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:
		- Limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
		- Formulary design;
		- Methods for determining usual, customary, and reasonable charges;
		- Use of fail-first policies or step therapy protocols;
		- Restrictions based on geographic location, facility type, provider specialty, and other
		- Criteria that limit scope or duration of benefits
		- A permanent exclusion of all benefits for a particular condition or disorder is not a NQTL; may be allowable if not otherwise prohibited
 |  |  |
| WAC 284-43-7060(2) | * + Plan standards: in-and-out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy.
 |  |  |
| WAC 284-43-7020(5)(b) | * If a health plan or issuer classifies providers into tiers, and varies cost-sharing based on the different tiers, there must be no 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.
 |  |  |
|  |  |  |  |  |  |
| **PKU Phenylketonuria Formula** |  | RCW 48.21.300;WAC 284-50-260(2) | * Plan must provide coverage for the formulas necessary for the treatment of phenylketonuria
 |  |  |
|  |  |  |  |  |  |
| **Prescription Medications****Prescription Medications****(Cont’d)****Prescription Medications (Cont’d)** | Requirement to cover contraceptive same as other RX drugsRequirement to cover contraceptive same as other RX drugs(Cont’d) |  | **Requirements for plans that cover prescription drugs. If plan does not cover prescription drugs, skip this section.** |  |  |
| 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)(c) | * + Plan may require cost sharing, such as copayments or deductibles, for prescription contraceptives and for services associated with the prescribing, dispensing, delivery, distribution, administration, and removal of the prescription contraceptives, to the same extent that such cost sharing is required for other covered prescription drugs, devices or services.
 |  |  |
| 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.
 |  |  |
| Coverage of drugs for “off-label” use | WAC 284-30-450(4)(a)(i) | * 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)(ii) | * + In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or
 |  |  |
| (4)(a)(iii) | * + By the Federal Secretary of Health and Human Services.
 |  |  |
| WAC 284-30-450(4)(b) | * Coverage of a drug for such “off-label” use must also include medically necessary services associated with the administration of the drug.
 |  |  |
| WAC 284-30-450(4)(c) | * Coverage for off-label use is not required when the FDA has determined its use to be contra-indicated.
 |  |  |
| WAC 284-30-450(4)(d) | * Coverage is not required for experimental drugs not otherwise approved for any indication by the FDA.
 |  |  |
| Benefit MandatesBenefit Mandates (Cont’d) | RCW 48.21.300; | State benefit requirements classified to the prescription drug services category include:* Medical formula to treat PKU;
 |  |  |
| 48.21.143 | * Diabetes supplies ordered by the physician (Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary);
 |  |  |
| RCW 48.21.241(2)(c)(ii) | * Mental health prescription drugs to the same extent, and under the same terms and conditions, as other prescription drugs covered by the plan.
 |  |  |
| Pharmacists – Eye Drop Refills  | RCW 18.64.530 | Forms may not include any provision conflicting with the following: A pharmacist is authorized, without consulting a physician or obtaining a new prescription or refill authorization from a physician, to provide for one early refill of a prescription for topical ophthalmic products if:  |  |  |
| RCW 18.64.530(1) | • The refill is requested by a patient at or after seventy percent of the predicted days of use of  |  |  |
| 18.64.530(1)(a) | * + The date the original prescription was dispensed to the patient; or
 |  |  |
| 18.64.530(1)(b) | * + The date that the last refill of the prescription was dispensed to the patient;
 |  |  |
| RCW 18.64.530(2) | * + The prescriber indicates on the original prescription that a specific number of refills will be needed; and
 |  |  |
| RCW 18.64.530(3) | * + The refill does not exceed the number of refills that the prescriber indicated.
 |  |  |
|  |  |  |  |  |  |
| **Preventive Screening** | Benefit Mandates | RCW 48.20.393 | * Mammogram services, both diagnostic and screening. WAC 284-43-5642(9)(e)(ii)
 |  |  |
| WAC 284-50-270(3) | * + Plan can apply standard contract provisions for **diagnostic** (not screening)mammograms applicable to other benefits such as deductible cost sharing. E.g., may apply deductible and copay requirements; and
 |  |  |
| RCW 48.21.227 | * Prostate cancer screening if delivered upon the recommendation of the patient’s physician, ARNP, or Physician Assistant. WAC 284-43-5642(9)(e)(iii)
 |  |  |
|  |  |  |  |  |  |
| **Prior Authorization****Prior Authorization (Cont’d)** | Standards and CriteriaStandards and Criteria (Cont’d) | 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(2) | * Plan may not require prior authorization for an evaluation and management visit or an initial treatment visit with a contracted provider in a new episode of chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies.
	+ Plan may require a referral or prescription for these therapies, other than chiropractic.
 |  |  |
| 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.
 |  |  |
| 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.
 |  |  |
| RCW 48.43.016(4)RCW 48.43.016(4)(Cont’d) | * 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.
 |  |  |
| 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.
 |  |  |
|  | WAC 284-170-200(4) | * Where an issuer establishes medical necessity or other prior authorization procedures, it must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.
 |  |  |
|  |  |  |  |  |  |
| **Provider Requirements****Provider Requirements****(Cont’d)****Provider Requirements****(Cont’d)** |  |  | **Requirements for plans that use a network. If plan does not use a network, skip this section.** |  |  |
| Access to Primary Care ProvidersAccess to Primary Care Providers(Cont’d) | 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.
 |  |  |
| RCW 48.43.515(5) | * + Plan can restrict coverage to in-network chiropractors and utilize managed care and cost containment techniques and processes.
 |  |  |
| Second OpinionSecond Opinion (Cont’d) | RCW 48.43.515(6) | * Contract must explain how to obtain a second opinion consultation. WAC 284-170-360(5)
 |  |  |
|  | * + Carrier must cover 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.
 |  |  |
| “Participating Provider” | WAC 284-170-421(2) and (3) | * 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.
 |  |  |
|  |  |  |  |  |  |
| **Subrogation** |  | Thiringer v. AmericanMotors 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 |  |  |
| * Inform enrollees that legal expenses will be apportioned equitably, whether or not recovery is made.
 |  |  |
| * The Contract must not have any provision which would inappropriately require full reimbursement for all medical expenses.
 |  |  |
| * The contract cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.
 |  |  |
|  |  |  |  |  |  |
| **Telemedicine****Telemedicine****(Cont’d)****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 | 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
 |  |  |
| 48.43.735(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.
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| Rules for “Originating Sites”Rules for “Originating Sites”(Cont’d) | RCW 48.43.735(3)(a) | * An originating site for a telemedicine health care service includes a:
	+ Hospital;
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| 48.43.735(3)(b) | * + Rural health clinic;
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| 48.43.735(3)(c) | * + Federally qualified health center;
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| 48.43.735(3)(d) | * + Physician's or other health care provider's office;
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| 48.43.735(3)(e) | * + Community mental health center;
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| 48.43.735(3)(f) | * + Skilled nursing facility; or
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| RCW 48.43.735(3)(g) | * + Renal dialysis center, except an independent renal dialysis center.
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| 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.
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| RCW 48.43.735(5) | * Plan may not distinguish between originating sites that are rural and urban in providing this coverage.
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| 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.
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| 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.
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| 48.43.735(8)(d) | * "Originating site" means the physical location of a patient receiving health care services through telemedicine;
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| “Store and Forward Technology” Definition | RCW 48.43.735(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****Transgender Services (Cont’d)** |  | 42 USC §18116; RCW 48.30.300Chapter 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.45 CFR §156.200(e); 45 CFR §92.206 and 92.207 (especially section (b)(4)); RCW 48.30.300; RCW 49.60.040 |  |  |
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| **Unfair and Discriminatory Practices** | False Represen-tation Prohibited | RCW 48.18.480 RCW 48.30.040;48.30.300 | * No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising on behalf of an Issuer. Nor shall the terms of a contract be misrepresented or misleading comparisons be made to induce a member to terminate or retain a contract or membership.
 |  |  |
| Discrimination Prohibited | RCW 48.30.300 | No Issuer may refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation as defined in RCW [49.60.040](http://app.leg.wa.gov/RCW/default.aspx?cite=49.60.040), or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured.  |  |  |
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| **10-Day Free Look****10-Day Free Look (Cont’d)** |  | RCW 48.20.013 | * 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.
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|  | * + Issuer must promptly refund any fee paid.
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|  | * + 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.
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|  | * + 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.
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