**LARGE GROUP ANALYST CHECKLIST**

**Disability Carrier**

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| Date(s) of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Issuer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Certificate Form Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State Tracker ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Policy = contract between group and issuer  
Contract = agreement as a whole, including policy, application, enrollment form, certificate of coverage, schedule of benefits (if any), and any other forms made a part of the contract by the terms of the policy

| **Topic** | **Subtopic** | **Reference** | **Specific Issue** | **Location**  **Form/Page #** |
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| **Appeals Procedures**  *Resources:*[ACA FAQ I](http://www.dol.gov/ebsa/faqs/faq-aca.html)**;** [DOL FAQs on Claims](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html)  **Appeals Procedures**  **(Cont’d)**  **Appeals Procedures**  **(Cont’d)**  **Appeals Procedures**  **(Cont’d)**  **Appeals Procedures**  **(Cont’d)**  **Appeals Procedures**  **(Cont’d)**  **Appeals Procedures**  **(Cont’d)**  **Appeals**  **Procedures**  **(Cont’d)**  **Appeals**  **Procedures**  **(Cont’d)**  **Appeals**  **Procedures**  **(Cont’d)**  **Appeals**  **Procedures**  **(Cont’d)**  **Appeals**  **Procedures**  **(Cont’d)**  **Appeals**  **Procedures**  **(Cont’d)** | Internal appeals / review of adverse benefit decisions under **Both** Grand-fathered and Non-Grand-fathered plans  Internal appeals / review of adverse benefit decisions under **Both** Grand-fathered and Non-Grand-fathered plans  (Cont’d) | 42 U.S.C.  §300gg-19 (a)  45 C.F.R. §147.136(b)  RCW 48.43.530(1)  WAC 284-43-510(1)  WAC 284-43-615(1)  RCW 48.43.530 (8)  WAC 284-43-511  WAC  284-43-615(2)(a)  RCW 48.43.530(9)  WAC 284-43-511(4)  WAC  284-43-615(2)(b)  RCW 48.43.530 (3)  RCW  48.43.530(4)  (a)and (b)  RCW  48.43.530(4)(c)    RCW 48.43.530(7)  WAC 284-43-510(3)  RCW 48.43.530(5)(b)  WAC 284-43-511(5)  WAC 284-43-615(2)(d)  RCW 48.43.530(5)(d)  WAC 284-43-615(2)(e)  RCW 48.43.530(5)(e)  WAC 284-43-615(2)(f)  WAC 284-43-620(5)  RCW 48.43.530(5)(f)  WAC 284-43-615(2)(g) | * Does the plan have a fully operational, comprehensive process for review of appeals / adverse benefit determinations?   + The issuer’s process for review of adverse benefit determinations must meet accepted national certification standards such as those used by the National Committee for Quality Assurance, except as otherwise required under Chapter 284-43 WAC. * Does the contract provide a clear explanation of the appeal / review of adverse benefit determination process?   + The process must be accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file an appeal or review of adverse benefit determination. * Does the contract notify the enrollee of the issuer’s responsibility to provide written notice to the enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility? * An issuer must process as an appeal / review of adverse benefit determination an enrollee's written or oral request that the issuer reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility.   + The issuer may not require that an enrollee file a complaint or grievance prior to seeking an appeal or review of an adverse benefit determination. * Does the contract notify the enrollee that, when the enrollee requests reconsideration of a decision to modify, reduce, or terminate an otherwise covered health service that the enrollee is receiving through the health plan, based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the issuer must continue to provide that health service until the appeal / review of adverse benefit determination is resolved?   + Does the contract notify the enrollee that, if the resolution of the appeal, review of adverse benefit determination, or external review affirms the issuer's decision, the enrollee may be responsible for the cost of this continued health service? * The issuer must assist the enrollee with the appeal process. * The issuer must cooperate with any representative authorized in writing by the enrollee. * The issuer must consider all information submitted by the enrollee or representative. * The issuer must investigate and resolve all appeals / requests for review of adverse benefit determination. |  |
| Internal Appeals under Grand-fathered Health Plans  Internal Appeals under Grand-fathered Health Plans  (Cont’d) | RCW 48.43.530(4)(a)  WAC  284-43-615(2)(c)  WAC  284-43-615(2)(h)  WAC 284-43-620(1)  WAC 284-43-620(2)  WAC 284-43-620(4)  WAC 284-43-620(6) | * The review of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including admission to, or continued stay in, a health care facility, is called and processed as an “Appeal”. * The issuer must:   + respond to oral and written appeals in a timely and thorough manner.   + notify the enrollee that an appeal has been received.   + Provide information on the enrollee's right to obtain second opinions. * An enrollee or the enrollee's representative, including the treating provider (regardless of whether the provider is contracted with the issuer) acting on behalf of the enrollee may appeal an adverse determination in writing. * The issuer must reconsider the adverse determination and notify the enrollee of its decision within fourteen days of receipt of the appeal.   + Issuer can extend time to complete the appeal up to a max of 30 days if it notifies the enrollee an extension is necessary;   + Issuer can delay the decision beyond thirty days ONLY with the informed, written consent of the enrollee. * Issuer must expedite either a written or oral appeal whenever delay would jeopardize the enrollee's life or materially jeopardize the enrollee's health.   + Must issue its decision no later than seventy-two hours after receipt of the appeal.   + If the treating health care provider determines that delay could jeopardize the enrollee's health or ability to regain maximum function, the issuer must presume the need for expeditious review, including the need for expedited determination in any independent review under WAC 284-43-630. * Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease. * The carrier shall issue to affected parties and to any provider acting on behalf of the enrollee a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. |  |
| Internal Reviews of Adverse Benefit Determi-nations under Non-Grand-fathered Health Plans  Internal Reviews of Adverse Benefit Determi-nations under Non-Grand-fathered Health Plans  (Cont’d)  Internal Reviews of Adverse Benefit Determi-nations under Non-Grand-fathered Health Plans  (Cont’d)  Internal Reviews of Adverse Benefit Determi-nations under Non-Grand-fathered Health Plans  (Cont’d) | WAC 284-43-525  29 C.F.R.  §2560.503-1(m)(4)  RCW 48.43.530(4)(b)  45 C.F.R. §147.136(a)(2)(i)  RCW 48.43.530(11)  WAC 284-43-525(8)  WAC 284-43-510(4)  RCW 48.43.530(5)(a)  WAC 284-43-510(4)  RCW 48.43.530(5)(g)  WAC 284-43-525(1)  WAC 284-43-525(2)  WAC 284-43-525(3)  WAC 284-43-525(4)  WAC 284-43-525(4)  WAC 284-43-525(5)  WAC 284-43-525(6)  RCW 284-43-525(7)  WAC 284-43-511(3)  WAC  284-43-511(4)(a)  WAC  284-43-511(4)(b)  WAC  284-43-511(4)(c)  WAC 284-43-511(5)  WAC 284-43-511(6)  WAC 284-43-520(2)  WAC  284-43-520(2)(a)  WAC  284-43-520(2)(b)  WAC  284-43-520(2)(c)(i)  WAC  284-43-520(2)(c)(ii)  WAC  284-43-520(2)(c)(iii)  WAC  284-43-520(2)(c)(iv)  WAC  284-43-520(2)(c)(v)  WAC 284-43-520 (3)  WAC 284-43-520 (1)(c) and (d) | * Carrier’s process for review of an adverse benefit determination must include an opportunity for internal review. * The review of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including admission to, or continued stay in, a health care facility, is called and processed as a “Review of Adverse Benefit Determination”.   + A denial or rescission of coverage is subject to review of adverse benefit determination, whether or not the rescission has an adverse effect on any particular benefit at the time. * The issuer must accept a request for internal review of adverse benefit determination if it is received within 180 days of the enrollee’s receipt of the determination. * To process an adverse benefit determination, the issuer must:   + Provide written notice of receipt to the enrollee within 72 hours after a request for review of the adverse benefit decision is received;   + Provide written notice of its resolution to the enrollee and, with the permission of the enrollee, to the enrollee's providers. * The issuer must notify the appellant of the review decision within fourteen days of receipt of the request for review, unless the adverse benefit determination involves an experimental or investigational treatment.   + - For good cause, an issuer may extend the time it takes to make a review determination by up to sixteen additional days without the appellant's written consent, but must notify appellant of the extension and the reason for the extension.     - The issuer may request further extension of its response time only if the appellant consents to a specific request for a further extension, the consent is reduced to writing, and includes a specific agreed-upon date for determination. In its request for the appellant's consent, the issuer must explain that waiver of the response time is not compulsory. * The issuer must provide the appellant with any new or additional evidence or rationale considered, whether relied upon, generated by, or at the direction of the issuer in connection with the claim. This must be provided free of charge to the appellant and sufficiently in advance of the date the notice of final internal review must be provided.   + If the appellant requests an extension in order to respond to any new or additional rationale or evidence, the issuer must extend the determination date for a reasonable amount of time, which may not be less than two days. * The review process must provide the appellant with the opportunity to submit information, documents, written comments, records, evidence, and testimony, including those obtained through a second opinion. * The appellant must have the right to review the issuer's file and obtain a free copy of all documents, records, and information relevant to any claim that is the subject of the determination being appealed. * The internal review process must include the requirement that the issuer affirmatively review and investigate the appealed determination, and consider all information submitted by the appellant prior to issuing a determination. * Review of adverse determinations must be performed by health care providers or staff who were not involved in the initial decision, and who are not subordinates of the persons involved in the initial decision. If the determination involves, even in part, medical judgment, the reviewer must be or must consult with a health care professional who has appropriate training and experience in the field of medicine encompassing the appellant's condition or disease and make a determination that is within the clinical standard of care for an appellant's disease or condition. * The internal review process for group health plans may require two levels of internal review prior to bringing a civil action. * Does the contract include information about the availability of Washington's designated ombudsman's office, the services it offers, and contact information? Does the contract specifically direct appellants to the OIC's consumer protection division for assistance with questions and complaints? * Does the contract’s notice of the process for review of adverse benefit decisions conform to federal requirements to provide this notice in a culturally and linguistically appropriate manner to those seeking review?   + In counties where ten percent or more of the population is literate in a specific non-English language, issuers must include in notices a prominently displayed statement in the relevant language or languages, explaining that oral assistance and a written notice in the non-English language are available upon request.   + This requirement is satisfied if the National Commission on Quality Assurance certifies the carrier is in compliance with this standard as part of the accreditation process. * Contract may not contain procedures or practices that discourage an appellant from any type of adverse benefit determination review. * Issuer may reverse its initial adverse benefit determination at any time during the review process. In that case, issuer must provide written or electronic notification immediately, but in no event more than two business days of making the decision. * An issuer can provide documents related to adverse benefit determinations and review of adverse benefit determinations electronically, but ONLY IF:   + The enrollee affirmatively consents, in electronic or nonelectronic form, to receiving documents through electronic media and has not withdrawn such consent.     - If the documents are to be furnished electronically, the appellant must have affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates his ability to access the electronically-provided information, and must have provided an address for receipt of electronically furnished documents;   + Prior to consenting, the enrollee must be provided, in electronic or nonelectronic form, a clear and conspicuous statement indicating:     - The types of documents to which the consent would apply;     - That consent can be withdrawn at any time without charge;     - The procedures for withdrawing consent and for updating the individual's electronic address for receipt of electronically furnished documents or other information;     - The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and     - Any hardware and software requirements for accessing and retaining the documents.   + After consent, if a change in hardware or software requirements to access or retain electronic documents creates a material risk that an enrollee will be unable to access or retain such documents, the issuer must provide information about the new requirements and the opportunity to withdraw consent without consequences. The issuer must request and receive a new consent to electronically provided documents, following such a hardware or software requirement change. * With respect to documents regarding adverse benefit determinations and review of such determinations, an issuer furnishing such documents electronically is deemed to satisfy the notice and disclosure requirements if:   + at the time a document is furnished electronically, the issuer provides notice (in electronic or nonelectronic form) that apprises the recipient of:     - the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., “the attached document describes the internal review process used by your plan”); and     - The recipient’s right to request and obtain a paper version of such document; AND   + The issuer furnishes the appellant or their representative with a paper version of the electronically furnished documents if requested. |  |
| Expedited Internal Reviews of Adverse Benefit Determinations under Non-Grand-Fathered Plans  Expedited Internal Reviews of Adverse Benefit Determinations under Non-Grand-Fathered Plans  (Cont’d) | RCW 48.43.530(5)(c)  WAC  284-43-540(1)(a)  WAC  284-43-540(1)(c)  WAC  284-43-540(1)(b)  WAC 284-43-540(5)  WAC 284-43-540(2)  WAC 284-43-525  WAC  284-43-540(1)(b)  WAC 284-43-540(3)  RCW 48.43.530(5)(c)  WAC 284-43-540(4)  WAC  284-43-540(4)(a)  WAC  284-43-540(4)(b)  WAC 284-43-540(6)  WAC 284-43-540(7) | * The Issuer must provide an expedited review process at any point in the review process IF:   + The appellant is currently receiving or is prescribed treatment or benefits that would end due to the adverse benefit determination; OR   + The determination is related to an issue related to admission, availability of care, continued stay, or emergency health care services where the appellant has not been discharged from the emergency room or transport service; OR   + the ordering provider or the issuer's medical director reasonably determines that following the normal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or would subject the appellant to severe and intolerable pain.     - If the treating health care provider determines that a delay could jeopardize the enrollee's health or ability to regain maximum function, the issuer must presume the need for expedited review, and treat the review request as such, including the need for an expedited determination of an external review under RCW 48.43.535. * Appellant is not entitled to expedited review if the treatment has already been delivered and the review involves payment for the delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness, or disease. * Does the process provide that the enrollee’s treating provider may seek expedited review on the patient’s behalf, regardless of whether the provider is contracted with the issuer? * An expedited review may be filed by an appellant, the appellant's authorized representative, or the appellant's provider orally, or in writing. * The issuer must respond as expeditiously as possible to an expedited review request, preferably within twenty-four hours, but in no case longer than seventy-two hours. The decision regarding an expedited review of adverse benefit determination must be made within 72 hours of the date the request for review is received.   + The issuer's response to an expedited review request may be delivered orally, and must be reduced to and issued in writing not later than 72 hours after the date of the decision. Regardless of who makes the issuer's determination, the time frame for providing a response to an expedited review request begins when the issuer first receives the request. * If the issuer requires additional information to determine whether the service being reviewed is covered, the issuer must request such information as soon as possible after receiving the request for expedited review. * An issuer may require exhaustion of the internal appeal process before appellant may request external review in urgent care situations that justify expedited review. * Expedited review must be conducted by appropriate clinician(s) in the same or similar specialty as would typically manage the case being reviewed. The clinician(s) must not have been involved in making the initial adverse determination. |  |
| Independent Review of appeals / Review of Adverse  Benefit Determi-nations (“IRO”) for **both** Grand-fathered and Non-Grand-fathered plans  Independent Review of appeals / Review of Adverse Benefit Determinations (“IRO”) for **both** Grand-fathered and Non-Grand-fathered plans  (Cont’d)  IRO for **both** Grand-fathered and Non-Grand-fathered plans  (Cont’d) | 42 U.S.C.  §300gg-19(b)  RCW 48.43.535(2)  WAC 284-43-550  RCW 48.43.535(2)  WAC 284-43-530(1)  WAC 284-43-550(2)  WAC 284-43-630(1)  WAC  284-43-550(4)(a)  WAC  284-43-630(3)(a)  WAC  284-43-550(4)(c)  WAC  284-43-630(3)(b)  RCW 48.43.535(5)  RCW 48.43.535(7)(a)  RCW 48.43.535(7)(a)  RCW 48.43.535(8)  RCW 48.43.535(9) | * An enrollee may seek review by a certified independent review organization of an issuer's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting the issuer's internal appeals / review of adverse benefit decision process and receiving a decision that is unfavorable to the enrollee.   + Enrollee may also seek review by a certified independent review organization after the carrier has exceeded the timelines provided in RCW 48.43.530, without good cause and without reaching a decision. * Issuers must use the rotational registry system of certified independent review organizations (IROs) established by OIC, and may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in WAC 246-305-030. * Issuers must make available to the enrollee and to any provider acting on behalf of the enrollee all materials provided to the IRO. * Issuers must provide IROs with all relevant clinical review criteria used by the issuer and other relevant medical, scientific, and cost-effectiveness evidence, the attending or ordering provider's recommendations, and a copy of the terms and conditions of coverage under the relevant health plan. * Enrollees must have at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review. * An enrollee or carrier may request an expedited external review if the issuer’s decision to deny, modify, reduce, or terminate coverage or payment for a health care service:   + concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or   + involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. * The independent review organization must make its determination to uphold or reverse the issuer’s decision, and notify the enrollee and the issuer of its determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review.   + If the notice is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision. * Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges. * When an enrollee requests independent review of an issuer's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the issuer's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the issuer must continue to provide the health service if requested by the enrollee until a determination is made.   + If the determination affirms the issuer's decision, the enrollee may be responsible for the cost of the continued health service.   Note: Washington has demonstrated that it meets parallel process to federal external review standards, so a plan does not have to separately follow federal law. See chart: [www.cms.gov/cciio/resources/files/external\_appeals.html](http://www.cms.gov/cciio/resources/files/external_appeals.html). |  |
| Independent Review of health care disputes (“IRO”) for Grand-fathered plans  IRO for Grand-fathered plans  (Cont’d) | WAC 284-43-535(5)  RCW 48.43.535(2)  WAC 284-43-530(1)  WAC 284-43-530(2)  WAC  284-43-530(2)(a)  WAC  284-43-530(2)(b)  WAC 284-43-530(3)  WAC 284-43-530(4) | * Appellant must be given up to 180 days following receipt of written notification of the internal review determination to file a request for external review. If external review is not requested, the internal review decision is final and binding. * If the issuer fails to strictly adhere to its internal review requirements, the internal review process is deemed exhausted, and the appellant may request external review without receiving an internal review determination.   + Issuer may challenge external review requested due to failure to adhere to requirements (either to the IRO or to a court) on the basis that the issuer’s violations are *de minimis*, and do not prejudice the appellant.   + Exception applies only if the IRO or court determines that the issuer has demonstrated that the violation was for good cause or was due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and appellant.   + Exception is not available, and the challenge may not be sustained, if the violation is part of a pattern or practice of violations by the carrier or health plan.   + Appellant may request a written explanation of the violation from the carrier and the carrier must provide such explanation within ten calendar days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.   + If the challenge is successful and the IRO or court determines that the internal review process is not exhausted, the issuer must provide the appellant with notice that they may resubmit and pursue the internal appeal within a reasonable time, not to exceed ten days, of receiving the IRO’s determination, or entry of the court's final order. |  |
| External Review of Adverse Benefit Determi-nations for Non-Grand-Fathered Plans | WAC 284-43-550(1)  WAC  284-43-550(4)(b)  WAC  284-43-550(4)(d)  WAC 284-43-550(6)  WAC 284-43-550(5) | * Appellants must be provided the right to external review of adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. * Issuer may not establish a minimum dollar amount requirement for an appellant to seek external independent review. * IRO review must be provided without imposing any cost to the appellant or their provider. * Within one day of selecting the IRO, the issuer must notify the appellant of the name of the IRO and its contact information.   + The notice must explain that the IRO will accept additional information in writing from the appellant for up to five business days after it receives the assignment, which the IRO must consider when conducting its review.     - Upon receipt of this information provided by the appellant to the IRO, an issuer may reverse its final internal adverse determination. If it does so, it must immediately notify the IRO and the appellant. * An issuer may waive a requirement that internal appeals must be exhausted before an appellant may proceed to independent review of an adverse determination. |  |
| Concurrent Expedited Review of Adverse Benefit Determinations for Non-Grand-Fathered Plans | WAC 284-43-545(1)  WAC 284-43-545(2)  WAC 284-43-545(3) | * Issuer must offer the right to request concurrent expedited internal and external review of adverse benefit determinations.   + "Concurrent expedited review" means initiation of both the internal and external expedited review simultaneously. This is review of either utilization review decisions or treatment decisions during a patient's stay or course of treatment in an inpatient or outpatient health care setting so that the final adverse benefit determination is reached as expeditiously as possible. * When concurrent expedited review is requested, issuer may not make the determinations consecutively. The requisite timelines must be applied concurrently. * Issuer may deny a request for concurrent expedited review only if the conditions for expedited review are not met. Issuer may not require exhaustion of internal review if an appellant requests concurrent expedited review. |  |
| **Colorectal Cancer Exams and Lab Tests**  **Colorectal Cancer Exams and Lab Tests**  **(Cont’d)** |  | RCW 48.43.043(1)  RCW 48.43.043(1)(a)  RCW 48.43.043(1)(b)  RCW 48.43.043(2)  RCW 48.43.043(3)(a)  RCW 48.43.043(3)(b) | * Does the plan cover colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States preventive services task force or the federal centers for disease control and prevention? Benefits or coverage must be provided:   + For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's physician after consultation with the patient; and   + To a covered individual who is:     - At least fifty years old; or     - Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.   + Enrollees and providers must not be required to meet burdensome criteria or overcome significant obstacles to secure such coverage.     - Additional deductible or coinsurance for testing cannot be greater than an annual deductible or coinsurance established for similar benefits. If no similar benefit, deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer benefit required.   + Issuer is not required to provide for a referral to a nonparticipating health care provider, unless the carrier does not have an appropriate, available in-network provider.     - If issuer does refer to a nonparticipating provider, screening exam services or resulting treatment, if any, must be provided at in-network cost. |  |
| **Continuation of Care During Enrollee Absence** | Family and Medical Leave Act (“FMLA”) | FMLA  29 CFR §825 | Does the contract contain proper notification to the enrollee regarding medical coverage status during a period of leave under FMLA? |  |
| Labor Dispute | RCW 48.21.075 | Does the contract inform enrollees about, and is it consistent with labor dispute continuation provisions?   * Six month continuation period required for employee to directly pay premiums * Applies whether employer pays all or part of premium * All three actions – strike, lockout, other labor dispute – must appear in description of provision * Contract may not be changed during this period. * After six months, if the employee’s plan is no longer available, the employee must be given an opportunity to purchase an individual contract at the rate filed with OIC. |  |
| **Continuation Options Upon Termination**  **Continuation Options Upon Termination**  **(Cont’d)** | Consolidated Omnibus Budget Reconciliation Act (“COBRA”) | COBRA  29 U.S.C. §1161  RCW 48.44.400  26 C.F.R. 54.4980B-7 A-4(c)  26 C.F.R. 54.4980B-8  26 C.F.R. 54.4980B-7  A-4(a)  26 C.F.R. 54.4980B-4  A-1 (b) | Does the contract contain continuation of coverage language in compliance with federal law?   * Employees, spouses, and dependents who lose coverage may continue coverage up to 18 months if employment is terminated or reduction in hours of full time employment (other than for gross misconduct), or bankruptcy of a retiree plan * Enrollee pays premium * Spouse and dependent children may continue up to 36 months if:   + Coverage lost because of employee’s death   + Divorce or legal separation from employee   + Dependent children no longer meet Plan’s eligibility requirements (e.g., no longer eligible due to age)   + Employee becomes eligible for Medicare and ceases to participate in plan |  |
| Mandated offering - Continuation of Coverage | RCW 48.21.50 | * Did the issuer offer the employer an option to include a contract provision granting a person who becomes ineligible for coverage under the group contract the right to continue the group benefits for a period of time at a rate agreed upon? * The contract provision must provide that when such coverage terminates, the covered person may convert to a conversion plan. |  |
| Conversion  Offered | RCW 48.21.250(1)  RCW 48.21.250  (3)and(4)  RCW 48.21.250(2)(a)  RCW 48.21.250(2)(b)  RCW 48.21.250(2)(c)  WAC  284-52-020(1)  RCW 48.21.250(3)  RCW 48.21.250(2)(a)  RCW 48.21.250(4) | * Does the contract provide notice of the right to convert to a conversion contract upon termination from the group contract?   + To obtain conversion plan, must submit application and 1st months premium within 31 days after later of: termination of eligibility for group coverage or 31 days after person received notice of termination of coverage (unless conversion requirement satisfied by notifying enrollees of option to purchase on Exchange, then follow special enrollment rules.)   + Need not offer to:     - employee terminated for misconduct     - person eligible for Medicare     - person covered under another group hospital or medical plan * Does the issuer have on file and approved at least three conversion contracts with the OIC? (This can be satisfied by directing enrollees to the Exchange. Conversion plans are considered individual plans under the ACA.) * Does the conversion option provide continuous coverage, without a lapse? * Does the contract reflect that in the event an employee is denied a conversion contract due to misconduct, his or her spouse and dependents must be offered a conversion contract? * If issuer or group contract holder does not renew, cancels or otherwise terminates group contract, issuer must offer conversion contract to anyone who was covered, unless the person is eligible to obtain group hospital or medical expense coverage within 31 days after the termination or 31 days after received notice of termination, whichever is later. |  |
| **Contract Examination and Standards**  **Contract Examination and Standards**  **(Cont’d)** | Examination/ Disapproval | RCW  48.18.110 (2)  RCW  48.18.110(2)  RCW 48.43.005 | * Review for 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.   + Cannot contain any title, heading, or other indication of provisions which is misleading   + Must contain clear, definitive, WA state specific language for all terms, benefits, and conditions   + May not unreasonably restrict treatment or services   + Benefits must be reasonable in relation to the amount charged for the contract. * Definitions in the contract must be consistent with those in RCW 48.43.005 and RCW 48.21. |  |
| Exclusions, reductions and limitations | RCW 48.18.140(f) | * Does the contract or certificate of coverage contain a listing of exclusions, reductions, and limitations to covered benefits either included with the benefit provisions, or under an appropriate caption?   + Is any exclusion, reduction, or limitation which applies only to a particular benefit Included with the applicable benefit provision? |  |
| Required Format | WAC  284-58-050(3)  WAC  284-58-030(3) | * The style, arrangement, and over-all appearance of the contract must give no undue prominence to any portion of the text   + Is the type of a general style?   + Is the font size uniform, and of acceptable point size?   + “Text” means all printed matter except the name and address of the issuer, name or title of the policy, a brief description (if any), and captions and subcaptions * Is there a form number in the lower left-hand corner of the page of each form, including riders and endorsements? |  |
| Required  Standards | WAC  284-96-012(1)  RCW 48.21.050  RCW 48.21.070 | * A contract must not contain any provision which gives or purports to give the Issuer or its designee the authority to make a final or binding decision relative to the contract, or coverage thereunder. An enrollee must not be denied the right to have a controversy determined by legal or arbitration proceedings. * No such policy of group or blanket disability insurance shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time within which suit may be brought upon the policy, which in the opinion of the commissioner is less favorable to the individuals insured than would be permitted by the standard provisions required for individual disability insurance policies. * Any grace period must be specified in the contract.   + If payment is not made within the grace period, the contract may be terminated as of the due date of payment rather than at the end of the grace period. |  |
| **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)** | Disclosure of Coordination  Use of Model COB Provisions | WAC 284-51-200 | **If the plan satisfies all of the following criteria, you can skip the rest of the COB section. If not, review for all COB requirements.**   * Each certificate of coverage under a contract that provides for COB must contain at least in summary form, a description of the COB provision.   + Does the contract use the model COB provisions in WAC [284-51-255](http://apps.leg.wa.gov/wac/default.aspx?cite=284-51-255) Appendix A?   + Does the contract use the model “plain language description” of COB in WAC [284-51-260](http://apps.leg.wa.gov/wac/default.aspx?cite=284-51-260), Appendix B? |  |
| General  General  (Cont’d) | WAC  284-51-200(3)  WAC  284-51-200 (4)  WAC 284-51-200(5)  RCW 48.21.200(1)  WAC  284-51-230(1)  WAC  284-51-195(1) | * Issuers need not use the specific words and format provided in WAC [284-51-255](http://apps.leg.wa.gov/wac/default.aspx?cite=284-51-255) and the plain language explanation in WAC [284-51-260](http://apps.leg.wa.gov/wac/default.aspx?cite=284-51-260). Editing changes may be made by the issuer to fit the language and style of the rest of its contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred, and that indemnify. Modifications may be made provided they do not conflict with the requirements of this chapter. * A COB provision may not be used that permits a plan to reduce its benefits on the basis that:   + Another plan exists and the covered person did not enroll in that plan;   + A person could have been covered under another plan; or   + A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected. * No plan may contain a provision that its benefits are "always excess" or "always secondary" except under the rules permitted in Chapter 284-51 WAC. * A carrier may not administer COB in a way that reduces total benefits payable below an amount equal to 100% of total allowable expenses. * 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 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. * When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense. |  |
| Time Limit | WAC  284-51-215(1) | No issuer shall unreasonably delay payment of a claim by reason of the application of a COB provision. Any time limit in excess of 30 days is unreasonable. |  |
| Definition of “Plan” for purposes of COB  Definition of “Plan for purposes of COB  (Cont’d) | WAC  284-51-195(12)  WAC  284-51-195(12)(a)  WAC  284-51-195(12)(b)  WAC  284-51-195(12)(b)(i)  WAC  284-51-195(12)(b)(ii)  WAC  284-51-195(12)(b)(iii)  WAC  284-51-195(12)(b)(iv)  WAC  284-51-195(12)(c)(i)  WAC  284-51-195(12)(c)(ii)  WAC  284-51-195(12)(c)(iii)  WAC  284-51-195(12)(c)(iv)  WAC ]  284-51-195(12)(c)(v)  WAC  284-51-195(12)(c)(vi)  WAC  284-51-195(12)(c)(vii)  WAC  284-51-195(12)(c)(ix)  WAC  284-51-195(12)(c)(x)  WAC  284-51-195(12)(c)(xi)  WAC  284-51-195(12)(c)(xii) | * "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. * If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than this definition. * No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan as defined in Chapter 284-51 WAC. * "Plan" includes:   + Group, individual or blanket disability insurance contracts, and group or individual contracts marketed by issuers;   + Closed panel plans or other forms of group or individual coverage;   + The medical care components of long-term care contracts, such as skilled nursing care; and   + 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. * "Plan" does not include:   + Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;   + Accident only coverage;   + Specified disease or specified accident coverage;   + Limited benefit health coverage, as defined in WAC [284-50-370](http://apps.leg.wa.gov/wac/default.aspx?cite=284-50-370);   + 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;   + Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;   + Medicare supplement policies;   + A state plan under Medicaid;   + A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;   + 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 | WAC  284-51-200(7)  WAC  284-51-195(5) | * 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. Further, coordination of benefits may occur during the claim determination period even where there are no savings in the closed panel plan. * "Closed panel plan" means a plan that provides health benefits to covered persons in the form of services primarily through a panel of providers that are 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. |  |
| Rules for Coordination of Benefits  Rules for Coordination of Benefits (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits  (Cont’d)  Rules for Coordination of Benefits (Cont’d)  Rules for Coordination of Benefits (Cont’d) | WAC 284-51-205  WAC  284-51-205(1)(a)  WAC  284-51-205 (1)(b)  WAC  284-51-205 (1)(c)  WAC  284-51-205 (1)(d)  WAC  284-51-205 (2)(a)  WAC  284-51-245 (2)(a)  WAC  284-51-245 (2)(a)(i)  WAC  284-51-245 (2)(a)(ii)  WAC  284-51-245 (2)(a)(iii)  WAC  284-51-245 (2)(b)  WAC  284-51-245 (2)(c)  WAC  284-51-205 (2)(b)  WAC 284-51-205(4)  WAC  284-51-205 (4)(a)(i)  WAC  284-51-205 (4)(a)(ii)  WAC  284-51-205(4)(b)  WAC  284-51-205(4)(b)(i)  WAC 284-51-205 (4)(b)(i)(A)  WAC 284-51-205 (4)(b)(i)(B)  WAC  284-51-205 (4)(b)(ii)  WAC  284-51-205 (4)(b)(ii)(A)  WAC  284-51-205 (4)(b)(ii)(B)  WAC  284-51-205 (4)(b)(ii)(C)  WAC  284-51-205 (4)(b)(ii)(D)  WAC  284-51-205 (4)(b)(ii)(E)  (I)  (II)  (III)  (IV)  WAC  284-51-205(4)(b)(iii)  WAC  284-51-205(4)(c)(i)  WAC  284-51-205(4)(c)(ii)  WAC  284-51-205(4)(c)(iii)  WAC  284-51-205(4)(d)(i)  WAC  284-51-205(4)(d)(ii)  WAC  284-51-205(4)(d)(ii)  WAC  284-51-205(4)(e)(i)  WAC  284-51-205(4)(e)(ii)  WAC  284-51-205(4)(e)(iii)  (A), (B) and (C)  WAC  284-51-205(4)(e)(iv)  WAC  284-51-205(4)(f) | Does the contract contain any provisions that are inconsistent with or less favorable than these COB rules?   * The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. A plan may take into consideration the benefits paid or provided by another plan only when, under the COB rules, it is secondary to that other plan. * If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. * 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 this chapter. * If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the COB rules, has its benefits determined before those of that secondary plan. * 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.   + 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 that are inconsistent with the WAC rules (noncomplying plan) on the following basis:     - If the complying plan is the primary plan, it must pay or provide its benefits first;     - If the complying plan is the secondary plan under the order of benefit determination WACs, it must pay or provide its benefits first, but the amount of the 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     - 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.     - If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or 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.     - In no event may the complying plan 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 or service. In consideration of the advance, the complying plan is subrogated to all rights of the covered person 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. * 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 that are superimposed over base plan hospital and surgical benefits, and insurance coverages that are written in connection with a closed panel plan to provide out-of-network benefits.) * Order of benefit determination. Each plan determines its order of benefits using the first of the following rules that applies:   + 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.     - 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.   * 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:   + For a dependent child whose parents are married or are living together, whether or not they have ever been married:     - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or     - If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.   + For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:   + If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care 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;   + 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;   + If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions above for parents married or living together determine the order of benefits;   + 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   + If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child is as follows:     - The plan covering the custodial parent, first;     - The plan covering the custodial parent's spouse, second;     - The plan covering the noncustodial parent, third; and then     - The plan covering the noncustodial parent's spouse, last.   + For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as if those individuals were parents of the child. * Active employee or retired or laid-off employee.   + The plan that covers a person as an active employee (an employee who is 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.   + 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.   + 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   + 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.   + 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.   + This provision also does not apply if the above provisions regarding nondependents and dependents in (a) of this subsection can determine the order of benefits. * Longer or shorter length of coverage   + 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.   + To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person 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:     - A change in the amount or scope of a plan's benefits;     - A change in the entity that pays, provides or administers the plan's benefits; or     - A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.   + The person's 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 the person's coverage under the present plan has been in force. * If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans. |  |
| Rules for Secondary Plan Payment  Rules for Secondary Plan Payment  (Cont’d) | WAC 284-51-230(1)  WAC 284-51-230(3)  WAC  284-51-230(2)(a)  WAC  284-51-230(2)(b)  WAC  284-51-230(4) | * In determining the amount to be paid by the secondary plan if the plan wishes to coordinate benefits, the secondary plan must pay in an amount so 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. However, in no event shall the secondary carrier be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the enrollee be responsible for a deductible amount greater than the highest of the two deductibles. * “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:   + If the plan is secondary, all secondary gatekeeper requirements will be waived if the gatekeeper requirements of the primary plan have been met.   + 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. * When a plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate and record its savings from the amount it would have paid had it been primary, and must use these savings to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period, so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period. |  |
| Required Provisions:  “Facility of Payment”  “Right of Recovery”  “Notice to Covered Persons” | WAC 284-51-220  WAC 284-51-225  WAC 284-51-235 | If the plan provides for COB, does it contain provisions substantially as follows?   * "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." * "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. * A 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 the plans have received the information needed to pay the claim, the plans 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. |  |
| **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **(Cont’d)**  **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **(Cont’d)**  **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **(Cont’d)**  **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **(Cont’d)**  **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **(Cont’d)**  **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **(Cont’d)**  **Cost-Sharing Protections (Grandfathered and non-Grandfathered plans)**  **(Cont’d)** | Lifetime and annual dollar limits on dollar value of EHB | 42 USC §300gg-11(a)  45 CFR 147.126(a)  45 CFR § 147.126(c)  42 USC §300gg-11(b)  45 CFR  §147.126 (b)(1)  45 CFR §147.126(a)(2)(ii) | * Issuer and plan may not establish any lifetime or annual limit on the dollar amount of essential health benefits for any individual.   + The term “essential health benefits” means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.   + Per CMS Bulletin: DOL, Treasury, and HHS will consider a large group plan, or a grandfathered group health plan, to have used a permissible definition of EHB if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). The definition must be used consistently by the issuer. * Exception: May place lifetime or annual limits on the dollar amount of specific covered benefits that are not essential health benefits.   *Note: Restriction on lifetime or annual limits does not apply to FSAs, MSAs, or HSAs. In the case of HRAs that are integrated with other group health plan coverage that complies, the fact that benefits under the HRA itself are limited is not a violation.*  *Resource:* [FAQ on Essential Health Benefits Bulletin](http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf) (Q10) |  |
| Maximum out-of-pocket limit | 42 USC §18022(c)  45 CFR § 156.130(a)(2)  45 CFR § 156.130(c) | * Plan must comply with annual limit on cost-sharing (e.g., deductible, copayment, coinsurance) with respect to the essential health benefits.   + This single MOOP must apply to all essential health benefits under the plan (e.g., medical, prescription drug, and mental health benefits). Plans design may include separate OOP limits for different categories of benefits, provide that the combined amount does not exceed the single combined limit. * Exceptions:   + Plan may, but is not required to, count cost-sharing for non-essential health benefits or non-covered services toward the limit.   + If the plan uses a network of providers, plan may, but is not required to, count cost-sharing for out-of-network benefits toward the limit. * Annual limit:   + Generally:     - 2016: $6,850 for self-only and $13,700 for family   + For HSA-HDHPs:     - 2016: $6.550 for self-only and $13,100 for family   + The MOOP for self-only coverage applies to all individuals (regardless of whether the individual is in self-only or family coverage). For example, a family plan with a $13,700 family out-of-pocket limit cannot have cost sharing exceed $6,850 for any individual enrollee on the contract.   *Resources*: [ACA FAQ Part XII](http://www.dol.gov/ebsa/faqs/faq-aca12.html); [ACA FAQ Part XVIII](http://www.dol.gov/ebsa/faqs/faq-aca18.html); [2016 Annual Notice of Benefit and Payment Parameters](https://www.federalregister.gov/articles/2014/11/26/2014-27858/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016#h-108); [2016 Annual Notice of Benefit and Payment Parameters Fact Sheet](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Fact-Sheet-11-20-14.pdf); [IRS Rev. Proc. 2014-30](http://www.irs.gov/pub/irs-drop/rp-14-30.pdf) |  |
| Coverage of students on medically necessary leave of absence (Michelle’s Law) | 42 USC  §300gg–28(c)  42 USC  §300gg–28(b)  42 USC §300gg–28(d)  42 USC §300gg–28(e)  42 USC §300gg–28(a) | * If the plan requires a dependent child to be a student for coverage, does the contract contain a notice of coverage of a student on a medically necessary leave of absence, in understandable language? * Issuer and plan cannot terminate coverage of dependent child who was enrolled on the basis of being a student due to a medically necessary leave of absence before the earlier of:   + The date that is 1 year after the first day of the leave; or   + The date on which coverage would otherwise terminate under the terms of the coverage. * Dependent on medically necessary leave of absence is entitled to the same benefits as if the child continued to be a covered student who was not on a medically necessary leave of absence. * If there is a change in the manner in which the beneficiary/parent is covered and continues to cover the dependent, the changed coverage will apply for the remainder of the period of the medically necessary leave of absence. * “Medically necessary leave of absence” means a leave of absence or change of enrollment of a dependent child from a post-secondary education institution that:   + commences while the child is suffering from a serious illness or injury;   + is medically necessary; and   + causes the child to lose student status for purposes of coverage under the terms of coverage.   + Plan must receive written certification by a treating physician that states the child is suffering from a serious illness or injury and the leave of absence is medically necessary. |  |
| Coverage for individuals participating in approved clinical trials | 42 USC § 300gg-8(a)(1)  42 USC § 300gg-8(a)(4)  42 USC § 300gg-8(b)  42 USC  § 300gg-8(a)(2)  42 USC § 300gg-8(a)(3) | * If the plan provides coverage to “qualified individuals”:   + Cannot deny participation in an “approved clinical trial” for treatment of cancer or another life-threatening disease or condition;   + Cannot deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial;   + Cannot discriminate on the basis of participation in the trial.   + This includes an enrollee participating in an approved clinical trial conducted outside the state in which the enrollee resides. * “Qualified individual” means enrollee who is eligible to participate in the trial according to trial protocol, and either: (1) referring provider is a participating provider and has concluded that the trial would be appropriate for individual, or (2) individual provides medical or scientific information establishing that the trial would be appropriate. * “Approved clinical trial” means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and it is either: (1) federally funded or approved, (2) conducted under FDA investigational new drug application, or (3) drug trial exempt from FDA investigational new drug application. * “Routine patient costs” includes all items/services that would be typically covered if not enrolled in trial, but not: (1) the investigational item, device, or service, (2) items solely for data collection or analysis needs, and (3) service clearly inconsistent with widely accepted standards of care. * If an in-network provider is participating in a clinical trial, the issuer may require participation in the trial through the participating provider if the provider will accept the individual as a participant.   *Resources:* [DOL Checklist for Group Plans](http://www.dol.gov/ebsa/pdf/part7-2.pdf); [Compliance Assistance Guide](http://www.dol.gov/ebsa/publications/CAG.html); [ACA FAQ Part XV](https://www.google.com/?gws_rd=ssl#q=aca+faq+part+XV) |  |
| Preventive Services without Cost-Sharing  (Non-Grand-fathered Plans Only) | 42 USC  § 300gg-13 (a)(1-5)  45 CFR  §147.130 (a)(1)(i)  45 CFR  §147.130 (a)(1)(ii)  45 CFR  §147.130 (a)(1)(iii)  45 CFR  §147.130 (a)(1)(iv)  45 CFR  §147.130 (a)(1)  45 CFR  §147.130 (a)(2)(i)  45 CFR  §147.130 (a)(2)(ii)  45 CFR  §147.130 (a)(2)(iii)  45 CFR  §147.130 (a)(5)  45 CFR  §147.130 (b)(1)  45 CFR  §147.130 (a)(3)  45 CFR  §147.130 (a)(4) | * Issuer and plan must provide coverage for specified preventive services:   + Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF;   + Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC);   + Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, and adolescents; and   + Evidence-informed preventive care and screenings provided for in HRSA guidelines for women. * For the specified preventive services, plan cannot impose cost-sharing (e.g., deductibles, co-payments, coinsurance).   + If a preventive item or service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.   + If a preventive service is billed together with an office visit, and the primary purpose of the office visit is delivery of the preventive service, the plan cannot impose cost-sharing for the office visit.   + If a preventive service is billed together with an office visit, but the primary purpose of the office visit is NOT delivery of the preventive service, the plan may impose cost-sharing for the office visit.   + Plans can impose cost-sharing for treatment resulting from the recommended services. * Plans must cover any newly recommended services within one year after the date the recommendation or guidance is issued. * Plans with a provider network do not have to cover preventive services delivered out-of-network. * Plans may use reasonable medical management techniques to the extent not contrary to the recommended preventive services.   *Resources:* [ACA FAQ Part II](http://www.dol.gov/ebsa/faqs/faq-aca2.html); [ACA FAQ Part V](http://www.dol.gov/ebsa/faqs/faq-aca5.html); [ACA FAQ Part VI](http://www.dol.gov/ebsa/faqs/faq-aca6.html); [ACA FAQ Part XII](http://www.dol.gov/ebsa/faqs/faq-aca12.html). |  |
| Exemption and Accom-modation for Religious Employers related to coverage of preventive services (contra-ception)  Exemption and Accom-modation for Religious Employers related to coverage of preventive services (contra-ception)  (Cont’d)  Exemption and Accom-modation for Religious Employers related to coverage of preventive services (contra-ception)  (Cont’d) | 42 USC  § 300gg-13 (a)(1-5)  45 CFR  §147.130 (a)(1)(iv)(A-B)  45 C.F.R. §147.131(c)(1)(i)  45 C.F.R. §147.131(c)(1)(ii)  45 C.F.R. §147.131(c)(2)(i)(A)  45 C.F.R. §147.131(c)(2)(i)(B)    45 C.F.R. §147.131(c)(2)(ii)  45 C.F.R. §147.131(d)  45 C.F.R. §147.131(e)(1)  45 C.F.R. §147.131(e)(2)  45 C.F.R. §147.131(f)  45 CFR §147.131(a)  45 CFR §147.131(b)(1)  45 CFR §147.131(b)(2)  45 CFR §147.131(b)(3)  45 CFR §147.131(b)(4) | * A group plan established or maintained by an eligible organization that provides benefits through an issuer complies with the requirement to provide contraceptive coverage under the “preventive services” EHB if the eligible organization or group health plan provides either a copy of the self-certification (described below) to the issuer or a notice to the Secretary of HHS that it is an eligible organization and of its religious objection to coverage for all or a subset of contraceptive services.   + When the self-certification is provided directly to an issuer, the issuer has sole responsibility for providing contraceptive coverage under the plan in accordance with 45 CFR §147.130. An issuer may not require any further documentation from the eligible organization regarding its status as such.   + When a notice is provided to the Secretary of HHS, HHS will send a separate notification to the plan's issuer informing the issuer that HHS has received the notice and describing the issuer’s obligations. * The issuer must:   + Expressly exclude contraceptive coverage from the group’s plan; and   + Provide separate payments for any contraceptive services required to be covered under 45 CFR §147.130(a)(1)(iv) for enrollees for so long as they remain enrolled in the plan. * The issuer may not impose any cost-sharing requirements, or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or enrollees for contraceptive coverage.   + The issuer must segregate premium revenue collected from the eligible organization from the monies used to provide payments for contraceptive services.   + The issuer must provide payments for contraceptive services in a manner that is consistent with the nondiscrimination requirements under the PHS Act.     - If the group health plan of the eligible organization provides coverage for some but not all contraceptive services required to be covered under §147.130(a)(1)(iv), the issuer is required to provide payments only for those contraceptive services for which the group health plan does not provide coverage. However, the issuer may provide payments for all contraceptive services, at the issuer's option. * For each plan year to which this accommodation is to apply, an issuer required to provide payments for contraceptive services must provide to enrollees written notice of the availability of separate payments for contraceptive services. The notice must be contemporaneous with (to the extent possible), but separate from, any application materials distributed in connection with enrollment (or re-enrollment) in group health coverage that is effective beginning on the first day of each applicable plan year.   + The notice must specify that the eligible organization does not administer or fund contraceptive benefits, but that the issuer provides separate payments for contraceptive services, and must provide contact information for questions and complaints.   + Can use this model language, or substantially similar:   “Your [employer/institution of higher education] has certified that your [group health plan/student health insurance coverage] qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that your [employer/institution of higher education] will not contract, arrange, pay, or refer for contraceptive coverage. Instead, [name of health insurance issuer] will provide separate payments for contraceptive services that you use, without cost sharing and at no other cost, for so long as you are enrolled in your [group health plan/student health insurance coverage]. Your [employer/institution of higher education] will not administer or fund these payments. If you have any questions about this notice, contact [contact information for health insurance issuer].”   * If an issuer relies reasonably and in good faith on an organization’s representation that it is an eligible organization, and the representation is later determined to be incorrect, the issuer is considered to comply with any requirement under §147.130(a)(1)(iv) to provide contraceptive coverage if the issuer complies with these obligations.   + A group health plan is considered to comply with the requirement under 45 C.F.R. §147.130(a)(1)(iv) to provide contraceptive coverage if the plan complies with its obligations, whether or not the issuer complies with its obligations. * These rules apply to student health insurance coverage arranged by an eligible organization that is an institution of higher education the same as they apply to group coverage provided by an employer. * “Religious employer” means an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended. * “Eligible organization” means an organization that satisfies all of the following requirements:    + The organization opposes providing coverage for some or all of any contraceptive services required to be covered under 45 CFR § [147.130(a)(1)(iv)](http://www.law.cornell.edu/cfr/text/45/147.130#a_1_iv) on account of religious objections.   + The organization is organized and operates as a nonprofit entity.   + The organization holds itself out as a religious organization.   + The organization self-certifies that it satisfies these criteria, and makes such self-certification available for examination upon request by the first day of the first plan year to which the accommodation applies. The self-certification must be executed by a person authorized to make the certification on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under ERISA §107.   *Resource*: [CMS Fact sheet on contraceptive accommodation](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html) |  |
| **Dental Services not subject to contract or provider agreement** |  | RCW  48.21.147(1)(a)  RCW 48.21.147(1)(b) | * If the plan covers any dental services:   + It may not require, directly or indirectly, that a participating provider dentist provide services to an enrollee at a fee set by, or subject to the approval of, the issuer unless the dental services are covered services;   + It may not prohibit, directly or indirectly, a participating dentist from offering or providing to an enrollee dental services that are not covered services on any terms or conditions acceptable to the dentist and the enrollee. |  |
| **Diabetes**  **Diabetes**  **(Cont’d)** |  | RCW 48.21.143  RCW 48.21.143(2)(a)  RCW  48.21.143(2)(b)  RCW  48.21.143(3)  RCW  48.21.143(5) | * If the contract provides RX benefits, the contract must provide appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, for all subscribers diagnosed “Insulin using”, “Non-insulin using”, and “elevated blood glucose induced by pregnancy. This must include:   + insulin,   + syringes,   + injection aids,   + blood glucose monitors,   + test strips for:     - * blood glucose monitors,       * visual blood sugar reading, and       * urine testing     - insulin pumps and accessories to the pumps,     - insulin infusion devices,     - prescriptive oral agents for controlling blood sugar levels,     - foot care appliances for prevention of complications associated with diabetes, and     - glucagon emergency kits. * Whether or not the contract provides Rx Benefits, does it 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 health care providers with expertise in diabetes.   + ISSUER may restrict patients to seeing only health care providers who have signed participating provider agreements with the ISSUER or an insuring entity under contract with the issuer. * Benefits may be subject to customary cost sharing for all other similar services or supplies within the policy. * Services must be covered when deemed medically necessary. |  |
| **Disclosures**  **Disclosures**  **(Cont’d)**  **Disclosures**  **(Cont’d)** |  | RCW 48.43.510(3)  WAC 284-43-820(4)  RCW 48.43.510(1)(g)  WAC 284-43-820  RCW 48.43.510(1)(a)  RCW 48.43.510(1)(b)  RCW 48.43.510(1)(c)  RCW 48.43.510(1)(d)  RCW 48.43.510(1)(e)  RCW 48.43.510(1)(f)  RCW 48.43.510(1)(g)  RCW 48.43.510(2)  RCW 48.43.510(2)(a)  RCW 48.43.510(2)(b)  RCW 48.43.510(2)(c)  RCW 48.43.510(2)(d)  RCW 48.43.510(2)(e)  RCW 48.43.510(2)(f)  RCW 48.43.510(2)(h) | * Does the issuer provide to all enrollees and prospective enrollees a list of available disclosure items, including:   + Instructions on how to access and request copies in paper and electronic forms, and   + Web site links to the entire health plan disclosure information. * Does the plan clearly and prominently display an offer to provide the following information before purchase or selection? Information must be provided upon request (either by paper or electronic, whichever is requested). Must be prominently displayed and accessible on the issuer’s website and easily understood by the average plan participant.   + listing of covered benefits, including RX benefits, if any,     - copy of the current formulary, if any is used     - definitions of terms such as generic versus brand name, and     - policies regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits;   + listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based;   + statement of the carrier's policies for protecting the confidentiality of health information;   + statement of the cost of premiums and any enrollee cost-sharing requirements;   + summary explanation of the carrier's review of adverse benefit determinations and grievance processes;   + statement regarding the availability of a point-of-service option, if any, and how the option operates; and   + convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. * Does the contract contain the following written information or notify the enrollee that he is entitled to it upon request:   + Any documents, instruments, or other information referred to in the medical coverage agreement;   + A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether any entity must authorize the referral;   + Procedures, if any, that an enrollee must first follow for obtaining prior authorization  for health care services;   + A written description of any reimbursement or payment arrangements between the issuer and providers, including capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions;   + Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;   + An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan;   + Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data. |  |
| Notice regarding coverage required by WHCRA | Women’s Health and Cancer Rights Act of 1998 (“WHCRA”)  29 USC  §1185b(a-b)  42 USC § 300gg–52  [DOL Model Notices](http://www.dol.gov/ebsa/pdf/cagappc.pdf) | * Does the contract provide notice to each enrollee of the coverage required for mastectomy reconstruction, including surgery on the unaffected breast for symmetrical appearance, and prostheses, and physical complications of all states of mastectomy, including lymphedemas?   + Can use model notices created by the Department of Labor:     - Enrollment notice:   “If you have had or are going to have a mastectomy, you may be entitled  to certain benefits under the Women’s Health and Cancer Rights Act of  1998 (WHCRA). For individuals receiving mastectomy-related benefits,  coverage will be provided in a manner determined in consultation with  the attending physician and the patient, for:  \* All stages of reconstruction of the breast on which the mastectomy  was performed;  \* Surgery and reconstruction of the other breast to produce a  symmetrical appearance;  \* Prostheses; and  \* Treatment of physical complications of the mastectomy, including  lymphedema.  These benefits will be provided subject to the same deductibles and  coinsurance applicable to other medical and surgical benefits provided  under this plan. Therefore, the following deductibles and coinsurance  apply: [insert deductibles and coinsurance applicable to these benefits].  If you would like more information on WHCRA benefits, call your plan  administrator [insert phone number].   * + - Annual notice:   “Do you know that your plan, as required by the Women’s Health and  Cancer Rights Act of 1998, provides benefits for mastectomy-related services  including all stages of reconstruction and surgery to achieve symmetry  between the breasts, prostheses, and complications resulting from  a mastectomy, including lymphedema? Call your plan administrator at  [insert phone number] for more information.” |  |
| **Durable Medical Equipment** |  | RCW 48.21.143(2);  WHCRA, 29 USC §1185b  RCW 70.126.020  RCW 48.43.290 | Does the contract or certificate define equitable Durable Medical Equipment (“DME”) Benefits in the following situations?   * Durable medical equipment for diabetes when plan includes coverage for pharmacy services * Prostheses after mastectomy * Home Health Care benefit (as applicable under the plan’s terms), including rental of apparatus and equipment such as wheelchairs, hospital beds, respirators, splints, trusses, braces, or crutches needed for treatment. * Coverage for DME must include the sales tax, or use tax calculation in payment. |  |
| **Emergency**  **Treatment**  **Emergency Treatment**  **(Cont’d)**  **Emergency Treatment**  **(Cont’d)** |  | 42 U.S.C.  §300gg-19a(b)(2)(B)  RCW 48.43.005  42 U.S.C.  §300gg-19a(b)(2)(A)  RCW 48.43.005(13)  WAC 284-43-130(6)  RCW  48.43.093 (1)(a)  42 U.S.C.  §300gg-19a(b)(1)(A)  RCW  48.43.093 (1)(a)  42 U.S.C.  §300gg-19a(b)(1)(B-C)  45 C.F.R. 147.138(b)(2)(ii)  42 U.S.C.  §300gg-19a(b)(1)(D)  RCW  48.43.093 (1)(c)  RCW  48.43.093 (1)(c)  45 CFR §147.138(b)(3)(i)  45 CFR §147.138(b)(3)(i)(A-C)  RCW  48.43.093 (2)  RCW  48.43.093 (1)(d)  RCW  48.43.093 (2) | * Is the plan’s definition of "Emergency services" 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))”?   * Is the plan’s definition of "Emergency medical condition" consistent with RCW 8.43.005(13), or WAC 284-43-130(6), 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’?   * Does the plan cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed?   + The contract must not require prior authorization of emergency services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. * The plan must cover out-of-network emergency services necessary to screen and stabilize a covered person if a prudent layperson would have reasonably believed that use of an in-network emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider or facility.   + The issuer must not require prior authorization of emergency services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of an in-network emergency department would result in a delay that would worsen the emergency.   + Emergency out-of-network coverage must be consistent with scope of regular contract benefits.   + Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles, and an issuer may impose reasonable differential cost-sharing arrangements for out-of-network emergency services, if such differential between in-network and out-of-network cost-sharing does not exceed fifty dollars.   + Differential cost sharing for out-of-network emergency services beyond the point of evaluation and stabilization may not be applied if:     - Due to circumstances beyond the enrollees control, the enrollee was unable to go to an in-network emergency department in a timely fashion without serious impairment to their health; or     - A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that they would be unable to go to an in-network emergency department in a timely fashion without serious impairment to their health.     - In addition to the in-network cost-sharing, plan can balance bill individual for the excess of out-of-network provider charges, over the minimum amount the plan is required to pay (see below).     - Plan complies with the above cost-sharing requirements for out-of-network emergency services if it provides coverage at the level of the greatest of these three amounts: (1) the median in-network rate, (2) the usual, customary and reasonable rate (or similar rate determined using the plan or issuer’s general formula for determining payments for out-of-network services, or (3) the Medicare rate. *Note: See regulations for more specifics.*     - For inpatient admission, the issuer may require notification within a specified time frame or as soon thereafter as medically possible, but no less than twenty-four hours.       * The issuer must have someone available 24/7 for preauth of post-evaluation or post-stabilization services     - The issuer may reserve the right to require transfer of a hospitalized enrollee upon stabilization. |  |
| **Enrollee may obtain Services Outside the Plan** |  | RCW 48.43.085  RCW 48.43.087(2) | * Does the contract allow the enrollee to freely contract to obtain any medical services outside of the health plan on any terms the enrollee chooses? * Does the contract allow the enrollee to obtain mental health services solely at his own expense IF:   + The enrollee’s mental health care coverage is exhausted   + During an appeal or adverse certification process   + When an enrollee’s condition is excluded from coverage; or   + For any other clinically appropriate reason at any time. |  |
| **Eosinophilic Gastro-intestinal Associated Disorder – Elemental Formula** | Plans with effective dates on or after 1/1/2015 | RCW 48.43.176 (1)  RCW 48.43.176 (2) | Is the plan effective date after December 31, 2015?   * Must offer coverage for medically necessary elemental formula, regardless of delivery method, when a licensed provider with prescriptive authority diagnoses a patient with an eosinophilic gastrointestinal associated disorder and orders and supervises the use of the elemental formula. * Issuer may require prior authorization or impose other appropriate utilization controls in approving coverage for medically necessary elemental formula. |  |
| **Every Category of Provider**  **Every Category of Provider**  **(Cont’d)** |  | 42 U.S.C. §300gg-5(a)  *See* [ACA FAQ Part XV](http://www.dol.gov/ebsa/faqs/faq-aca15.html)  RCW  48.43.045 (1)(a)(i)  WAC 284-43-200(2)  RCW 48.43.515(1)  WAC 284-43-205(1)  RCW 48.43.045(1)(a)(ii)  WAC  284-43-205(2-3)  WAC 284-43-205(4)  WAC  284-43-205(4)(a)  WAC 284-43-205(5)  RCW 48.21.141  RCW 48.21.130  RCW 48.21.141  RCW 48.43.190  RCW 48.21.142  WAC 284-43-251(3) | * Plan and Issuer must not discriminate with respect to participation under the plan against any provider acting within the scope of that provider’s license or certification under applicable State law. (Reimbursement rates may vary based on quality or performance measures.) * 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.   + Providers can be required to conform with carrier standards for cost - Containment, administrative procedures, and provision of cost-effective, clinically effective services.   + 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.   + Plans may use restricted networks.   + Plans that use “gatekeepers” or “Medical Homes” for access to specialists may use them for access to specified categories of providers.   + Issuers may not offer coverage for services by certain categories of providers solely as a separately-priced optional benefit (e.g., chiropractic care; acupuncture). * 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](http://apps.leg.wa.gov/rcw/default.aspx?cite=18.71) RCW. * Does the contract cover chiropractic care on the same basis as any other care?   + Benefits cannot be denied on the basis that a service is not performed by a physician licensed under Chapter 18.57 or 18.71 RCW.   + 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 | For contracts offering 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**  **And**  **Investigational**    **Experimental**  **And**  **Investigational**  **(Cont’d)** |  | WAC 284-50-377(1)  WAC 284-50-377(2)  WAC  284-50-377(2)(a)  WAC  284-50-377(2)(b)  WAC  284-50-377(2)(b)  WAC 284-43-525(1)  WAC 284-50-377(3) | * If the contract includes exclusion, reduction or limitation for services that are experimental or investigational, is the definition of Experimental and Investigational services included in the contract?   + 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.     - If the ISSUER or an affiliated entity is the authority making the determination, it must state the criteria it will utilize to make the determination. This requirement may be satisfied by using one or more of the following statements, or other similar statements:     - "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."     - "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."   + 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. * 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. |  |
| **Grandfathered Plan Status**  **Grandfathered Plan Status**  **(Cont’d)**  **Grandfathered Plan Status**  **(Cont’d)**  **Grandfathered**  **Plan Status**  **(Cont’d)** |  | 45 CFR  §147.140 (a)(1)(i)  42 U.S.C. §18011(b)  45 CFR §147.140 (a)(4)  42 U.S.C. §18011(b)  45 CFR §147.140 (b)(1)  45 CFR  §147.140(a)(2)(i)  WAC 284-170-952(2)  45 CFR  §147.140 (a)(2)(ii)  45 CFR  §147.140 (a)(3)(i)  WAC 284-170-950(1)  45 CFR  §147.140 (g)(1)(i)  WAC  284-170-950(3)(a)  45 CFR  §147.140 (g)(1)(ii)  WAC  284-170-950(3)(b) 45 CFR  §147.140 (g)(1)(iii)  WAC 284-170-950(3)(c)  45 CFR  §147.140 (g)(1)(iv)  WAC  284-170-950(3)(d)  45 CFR  §147.140 (g)(1)(vi)  WAC  284-170-950(3)(f-h)  45 CFR  §147.140 (g)(1)(v)  WAC  284-170-950(3)(e)  45 CFR  §147.140 (a)(3)(ii)  29 CFR 2590.715-1251(a)(1)(ii)  45 CFR  §147.140 (b)(2)(i)  WAC  284-170-950(3)(a)  45 CFR  §147.140 (b)(2)(ii)  WAC 284-170-952(1)  WAC 284-170-950(8)  45 C.F.R.  §147.140 (c)  45 C.F.R.  §147.140 (d)  45 C.F.R.  §147.140 (e)  45 CFR §147.140 (f)  42 U.S.C. §18011(d)  45 CFR  §147.140 (g)(3)(i) | **Does the plan claim to be grandfathered? If no, skip this section and go on to the next section.**  A plan may claim grandfathered status if, for each benefit package or option:   * At least one person was enrolled in the plan on March 23, 2010; * At least one person has been covered since that time (not necessarily the same person, but at all times at least one person);   + If an individual was enrolled in the plan on March 23, 2010, grandfathered coverage includes coverage of their family members who enroll in their grandfathered coverage after March 23, 2010.   + A group health plan that provided coverage on March 23, 2010 and has retained its status as a grandfathered health plan is grandfathered health plan coverage for new employees (whether newly hired or newly enrolled) and their families enrolling in the plan after March 23, 2010. * The issuer must include a statement that it believes it is a grandfathered plan in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan;   + Model language can be used to satisfy this disclosure requirement:   “This [health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information].”   * The plan has maintained records documenting the terms of the plan in connection with the coverage that was in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered health plan; and * **None of the following have occurred** that would cause the plan to lose grandfathered status:   + The plan has eliminated all or substantially all benefits to diagnose or treat a particular condition, where “substantially all” means benefits for any “necessary element to diagnose or treat a condition.”   + The plan has increased a percentage cost-sharing requirement (e.g., coinsurance).   + The plan has increased a fixed-amount cost-sharing requirement other than a co-payment (e.g., deductible or out-of-pocket limit) such that the total percentage increase since March 23, 2010 exceeds the maximum allowed increase (medical inflation as percentage + 15 percentage points).   + The plan has increased a fixed-amount copayment, such that the increase since March 23, 2010 exceeds the greater of: the maximum allowed increase (medical inflation + 15 percentage points), or $5 + medical inflation.   + The plan has added or decreased an overall annual limit on benefits.   + There has been a decrease in the contribution rate by the employer (or employee organization) toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.   + The plan changed issuers after March 23, 2010, and the change was effective prior to November 15, 2010, and the plan provided documentation to the new issuer of the plan terms under the prior health coverage insufficient to determine whether any other change was made that would relinquish grandfather status.   + The plan was self-insured and changed to fully-insured after March 23, 2010, and the change was effective prior to November 15, 2010, and the plan provided documentation to the new issuer of the plan terms under the prior health coverage insufficient to determine whether any other change was made that would relinquish grandfather status.   + The plan has violated anti-abuse rules by:     - Engaging in a merger, acquisition, or business restructuring for the principal purpose of covering new individuals in a grandfathered plan.     - Transferring employees from one grandfathered plan to another grandfathered plan, if treating the terms of the 2nd plan as an amendment to the 1st plan would cause the 1st to lose grandfathered status, and there is no bona fide employment-based reason. * Issuer must designate on its filings whether a plan is grandfathered or nongrandfathered as required by the Washington SERFF filing instructions. * The provisions of the ACA relating to coverage for individuals participating in approved clinical trials and to annual limits do not apply to grandfathered health plans. * The ACA prohibition on lifetime limits apply to grandfathered plans for plan years beginning on or after January 1, 2014. * The ACA requirement for coverage of dependents up to age 26 apply to group grandfathered plans.   *Note: There are special rules for collectively-bargained plans.*  *Note: Medical inflation is the increase since March 2010 in the medical care component of the Consumer Price Index for All Urban Consumers, published by DOL.*  Resources: [ACA FAQs Part I](http://www.dol.gov/ebsa/faqs/faq-aca.html) (Q 2-6), [Part II](http://www.dol.gov/ebsa/faqs/faq-aca2.html) (Q 1-5), [Part IV](http://www.dol.gov/ebsa/faqs/faq-aca4.html) (Q 1-2), [Part VI](http://www.dol.gov/ebsa/faqs/faq-aca6.html) (Q1-6);  *See also*: DOL Checklist for Group Plans ([www.dol.gov/ebsa/pdf/part7-2.pdf](http://www.dol.gov/ebsa/pdf/part7-2.pdf)) and Compliance Assistance Guide ([www.dol.gov/ebsa/publications/CAG.html](http://www.dol.gov/ebsa/publications/CAG.html)) |  |
| **Grievance Procedures** |  | RCW 48.43.005(21)    WAC 284-43-711  RCW 48.43.530(8)  RCW 48.43.530(9)  RCW  48.43.530(4)(c)  WAC  284-43-721(3) | * "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. * Does the contract provide a clear explanation of the grievance process?   + Is the grievance process accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance?   + An issuer may not require that an enrollee file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination.   + Grievances are not adverse benefit determinations and do not establish the right to internal or external review of an issuer’s resolution of the grievance. |  |
| **Group Certificates** |  | RCW 48.21.080  Fittro v. Lincoln Natl Life Ins. Co., 111 Wn.2d 46 (1988). | * Does the certificate set forth in summary form the essential features of the coverage and who is covered? * If there is a conflict in language between the contract and certificate the certificate governs. |  |
| **Group Enrollment Requirements**  **Group Enrollment Requirements**  **(Cont’d)**  **Group Enrollment Requirements**  **(Cont’d)**  **Group Enrollment Requirements**  **(Cont’d)** | Collection and Use of Genetic Information | Genetic Information Nondiscrimination Act (“GINA”),  42 U.S.C. 300gg-4 (a)(6); (c)(1); (d)(1-2)  45 CFR  §146.122(c and d)  45 CFR §146.122(c)(2)  45 CFR §146.122(c)(5)  45 CFR §146.122(d)(2)(ii)  45 CFR §146.122(d)(1)(iii)  45 CFR §146.122(a)(3)  45 CFR §146.122(a)(5) | * No genetic information may be required prior to enrollment, in connection with that enrollment. * Plan may not request or require individuals to undergo genetic testing. * Plan may not request, require, or purchase genetic information for underwriting purposes. * Issuer cannot request or require genetic testing, unless:   + Testing requested by health care professional providing care;   + Testing requested for research purposes under specific conditions; * Issuer cannot collect genetic information prior to/in connection with enrollment, unless it is incidental to collecting other information. * Issuer cannot collect genetic information for underwriting purposes, unless medically appropriate:   + If an enrollee seeks a plan benefit, the issuer may limit or exclude the benefit based on whether the benefit is medically appropriate and the determination of whether the benefit is medically appropriate is not for underwriting purposes. Thus, if a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information. * “Genetic information” can include:   + Information about the individual, family member, or fetus of a pregnant woman.   + Information in genetic tests, manifestations of a condition, or participation in clinical research. * “Genetic information” does not include:   + Information about the sex or age of the individual. * “Genetic test” means an analysis of DNA, RNA, chromosomes, proteins, or metabolites to detects genotypes, mutations, or chromosomal changes. “Genetic test” does not include analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. E.g., a test for the BRCA1 or BRCA2 variant, or for the genetic variant associated with hereditary colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for alcohol or drugs is not a genetic test. |  |
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| Preexisting Conditions | 42 U.S.C. §300gg-7  42 U.S.C.  §300gg-3(b)(1)(A)  42 U.S.C.  §300gg-3(b)(1)(B)  42 U.S.C. §300gg-3(a)  45 CFR §147.108(a)  RCW 48.43.017  42 U.S.C. §300gg-7  RCW 48.21.235  RCW 48.21.235 | * Issuer cannot apply any waiting period longer than 90 days. * Does the plan correctly define “Preexisting Condition”?   + The term “preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.   + Genetic information may not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the information. * For plans with effective dates on or after 1/1/2014, there can be no preexisting condition exclusions. This includes grandfathered plans.   + Creditable coverage language is no longer required for plans that begin on or after 1/1/2015. * No person engaged in the business of insurance may 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. * No person engaged in the business of insurance may 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.   *Resources*: [ACA FAQ Part XVI](http://www.dol.gov/ebsa/faqs/faq-aca16.html) |  |
| Organ Transplant Waiting Period | 42 USC  §300gg-3(a)  WAC 284-43-878(3)(c) | The plan may not include a waiting period for organ transplant benefits because such a waiting period excludes, for the waiting period, benefits specifically relating to conditions requiring transplants. |  |
| Special Enrollment  Special Enrollment Periods  (Cont’d)  Special Enrollment Periods  (Cont’d) | 42 U.S.C.  §300gg-1(b)  45 C.F.R. §146.117(a)  45 C.F.R.  §146.117(a)(3)(iv)  42 U.S.C.  §300gg-1(f)(1)  45 C.F.R.  §146.117 (a)(3)(i)  42 U.S.C.  §300gg-1(f)(2)  45 C.F.R.  §146.117 (a)(2)(ii)  45 C.F.R.  §146.117(a)(3)(i–iii)  45 C.F.R. §146.117(b)(2)(ii-iv)  RCW 48.43.517  45 C.F.R. §146.117(a)(4)(i)  RCW 48.43.005(34)  45 C.F.R. §146.117(a)(4)(ii)  45 C.F.R.  §146.117 (b)(3)(iii)(A)  45 C.F.R.  §146.117 (b)(3)(iii)(B)  45 C.F.R.  §146.117(d)(1)  45 C.F.R.  §146.117(d)(2) | * Plan can use open enrollment periods but must offer Special Enrollment where required.   + Plan can require employee declining coverage for self or any dependent to state in writing whether the coverage is being declined due to other coverage     - Employee must be provided notice of requirement and consequences of failure to provide statement     - Plan cannot require more than the statement; e.g., that it be notarized   + If plan requires this statement and employee fails to provide it, plan is not required to provide special enrollment to the employee or any dependent * Does the plan offer enrollment to eligible persons regardless of open enrollment requirements (“special enrollment”), in the following situations:   + Employee loses coverage     - If the employee didn’t enroll during open enrollment because they had other coverage   + Dependent loses coverage     - During open enrollment, the dependent had other coverage     - Allow both dependent and employee to enroll, but not any other dependents unless they also have their own special enrollment qualifying event   + Employee or any dependent loses other coverage (other than for nonpayment or fraud) due to:     - Divorce or legal separation     - Cessation of dependent status (e.g., reach maximum age)     - Death of an employee under whose coverage they were a dependent     - Termination or reduction in the number of hours worked     - Leaving the service area of former plan     - Meeting or exceeding lifetime limits on former plan     - Discontinuation of former plan     - Discontinuation of employer contributions     - Exhaustion of COBRA continuation coverage   + Spouse or dependent becomes eligible for coverage (both current employee and spouse/dependent become eligible for special enrollment)     - Marriage (new dependents resulting from marriage included)     - Birth, adoption, placement for adoption   + When the Health Care Authority requests special enrollment for a child participating in a medical assistance program under chapter 74.09 RCW within 60 days of making a determination that it is cost-effective to enroll the child in that plan.     - Does the special enrollment period last at least 31 days after the qualifying event?     - Does coverage begin no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment?       * Exceptions: When special enrollment qualifying event is:         + Marriage: coverage must begin no later than the first day of the first calendar month beginning after the date the issuer receives the request for special enrollment.         + Birth, adoption, placement for adoption, or new dependent as a result of marriage: Coverage begins on the date of dependent’s birth, adoption, placement for adoption, or marriage if new dependent resulting from marriage         + Even if the special enrollment happens to coincide with a late enrollment opportunity does the plan treat special enrollee as special enrollee, rather than late enrollee?   Are special enrollees offered all benefit packages available to similarly situated enrollees who enroll when first eligible?  Plan cannot have different terms for special enrollees: no higher rate, longer pre-existing condition exclusion, different cost sharing.  *Resources:* [DOL Checklist for Group Plans](http://www.dol.gov/ebsa/pdf/part7-2.pdf) and [Compliance Assistance Guide](http://www.dol.gov/ebsa/pdf/caghipaa.pdf). |  |
| **Guaranteed Issue**  **Guaranteed Issue**  **(Cont’d)** |  | 45 CFR §147.104(b)(1)(i)  42 U.S.C.  §300gg-1  RCW 48.43.035 (1)  RCW 49.60.174(2)  RCW 48.30.300  RCW 48.43.025(1)  42 U.S.C.  §300gg-3 (b)(4);  42 U.S.C.  §300gg-7  42 U.S.C.  §300gg-3(a)  45 CFR 147.108 | * Does the issuer offer to any employer or qualified group in the state all products approved for sale in that market at any time in the year? * Does the issuer accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, religion, national origin, health condition, geographic location, employment status, socioeconomic status, the presence of any sensory, mental, or physical handicap, other condition or situation, or actual or perceived status regarding HIV or Hepatitis C? * Issuer may not reject individual for coverage based upon preexisting conditions of the individual or deny, exclude, or limit coverage for an individual’s preexisting health conditions, but may impose up to a 90 day benefit waiting period before the individual is eligible for benefits under the plan. * For plans with an effective date on or after 1/1/2014: No preexisting condition limitations are allowed.   *Resources*: DOL Checklist for Group Plans ([www.dol.gov/ebsa/pdf/part7-2.pdf](http://www.dol.gov/ebsa/pdf/part7-2.pdf)); Compliance Assistance Guide ([www.dol.gov/ebsa/publications/CAG.html](http://www.dol.gov/ebsa/publications/CAG.html)) |  |
| **Guaranteed**  **Renewability** |  | 42 USC §300gg-2(a)  RCW 48.43.035 (2)  42 USC §300gg-2(b)  RCW 48.43.035(3)(a)  RCW 48.43.035(3)(b) RCW 48.43.035(3)(c)  RCW 48.43.035 (3)(d)  RCW 48.43.035(3)(e)  RCW 48.43.035(3)(f)  RCW 48.43.035(3)(g)  42 USC §300gg-2(c)  RCW 48.43.035(4) | * Does the contract contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan? (Issuer must renew or continue coverage at the option of the plan sponsor.)   + A plan is "renewed" when it is continued beyond the earliest date upon which, at the issuer's sole option, the plan could have been terminated for other than nonpayment of premium. The issuer may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section. * The issuer may cancel or nonrenew the plan for:   + Nonpayment of premium;   + Violation of published policies of the issuer approved by the OIC;   + Enrollees entitled to become eligible for Medicare due to age who fail to apply for Medicare or Medicare supplement plan, or other plan offered by the issuer pursuant to federal laws and regulations;   + Enrollees who fail to pay any deductible or copayment amount owed to the issuer and not the provider of health care services;   + Fraudulent acts as to the issuer;   + Material breach of the health plan; or   + Change or implementation of federal or state laws that no longer permit the continued offering of such coverage. * Guaranteed renewability is not required in certain cases where the issuer discontinues a plan or leaves the service area or market, see RCW 48.43.035(4). |  |
| **Home Care and Hospice Coverage**  **Home Care and Hospice Coverage**  **(Cont’d)**  **Home Care and Hospice Coverage**  **(Cont’d)**  **Home Care and Hospice Coverage**  **(Cont’d)** |  | RCW 48.21.220(1)  RCW 48.21.220(2)  RCW 48.21.220(2)(g)  RCW 48.21.220(2)(e)  RCW 70.126.020(1)(a)  RCW 70.126.020(1)(b)(i)RCW 70.126.020(1)(b)(ii)  RCW 70.126.020(1)(b)(iii)  RCW 70.126.020(2)(a)  RCW 70.126.020(2)(b)  RCW 70.126.020(2)(c)  RCW 70.126.020(2)(d)  RCW 70.126.020(3)(a)  RCW 70.126.020(3)(b)  RCW 70.126.020(3)(c)  RCW 70.126.020(3)(d)  RCW 70.126.020(3)(e)  RCW 70.126.020(3)(f)  RCW 48.21.220(2)(b)  RCW 48.21.220(2)(a)  RCW 48.21.220(2)(c)  RCW 48.21.220(2)(d)  RCW 48.21.220(2)(h)  RCW 48.21.220(5) | * If the plan covers hospitalization, does the filing show that the issuer made an offer of optional coverage for home health care and hospice benefits for persons who are homebound and would otherwise require hospitalization? * If the plan covers home health care and hospice care, does it conform to the following standards, limitations, and restrictions?   + Does the home health care coverage provide benefits for a minimum of one hundred thirty health care visits per calendar year?     - A visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit.   + Does the coverage provide benefits for, and restrict benefits to, services rendered by home health and hospice agencies licensed under chapter [70.127](http://apps.leg.wa.gov/rcw/default.aspx?cite=70.127) RCW?   + Must home health care be provided by a home health agency and delivered by a RN, physical therapist, occupational therapist, speech therapies, or home health aide on a part-time or intermittent basis?   + Must it include     - Prescription drugs and insulin?     - Rental of DME needed for treatment, such as wheelchairs, hospital beds, respirators, splints, trusses, braces, or crutches?     - Supplies normally used for hospital inpatients and dispensed by the home health agency such as oxygen, catheters, needles, syringes, dressings, materials used in aseptic techniques, irrigation solutions, and IV fluids?     - Coverage may include the following if medically necessary, ordered by the attending physician, and included in the approved treatment plan:       * Licensed Practical nurses       * Respiratory therapists       * Social workers with a Master’s degree or further advanced degree from an accredited, approved social work program       * Ambulance services due to the patient’s physical condition or for unexpected emergencies     - Coverage for home health care does NOT include       * Nonmedical, custodial, or housekeeping services except by home health aides as ordered in the approved treatment plan;       * “Meals on Wheels” or similar food service;       * Nutritional guidance;       * Services performed by family members;       * Services not included in the approved plan of treatment; or       * Supportive environmental materials (handrails, ramps, telephones, air conditioners, and similar devices) * Is the coverage structured to create incentives for the use of home health care and hospice care as an alternative to hospitalization? * The coverage may have the following characteristics:   + include reasonable deductibles, coinsurance provisions, and internal maximums;   + contain provisions for utilization review and quality assurance;   + require that home health agencies and hospices have written treatment plans approved by a physician licensed under chapter [18.57](http://apps.leg.wa.gov/rcw/default.aspx?cite=18.57) or [18.71](http://apps.leg.wa.gov/rcw/default.aspx?cite=18.71) RCW, and may require such treatment plans to be reviewed at designated intervals; * The coverage may be structured so that services or supplies included in the primary contract are not duplicated in the optional home health and hospice coverage. * The issuer, as a condition of reimbursement, may require compliance with home health and hospice certification regulations established by the United States Department of Health and Human Services. |  |
| Hospice Care | RCW 70.126.030(1)  RCW 70.126.030(2)  RCW 70.126.030(3)(a)  RCW 70.126.030(3)(b)  RCW 70.126.030(3)(c)  RCW 48.21.220(2)(f) | * Must Hospice care be provided by a hospice? * Must a written hospice care plan be approved by a physician and reviewed at designated intervals? * Does hospice care include the following when ordered by a physician and included in the approved treatment plan:   + Short term inpatient care;   + Care of the terminally ill in an individual’s home on an outpatient basis;   + Respite care that is continuous care in the most appropriate setting for a maximum of five days per 3 months of hospice care? * Does the hospice care coverage provide benefits for terminally ill patients for an initial period of care of not less than six months?   + Coverage may provide benefits for an additional six months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the attending physician. |  |
| Long Term Care  Long Term Care  (Cont’d) | RCW 48.43.125(1)(a)  RCW 48.43.125(1)(b)  RCW 48.43.125(1)(c)  RCW 48.43.125(1)(d)  RCW 48.43.125(2) | * Does the plan provide coverage for a person at a long-term care facility following the person's hospitalization? If so, it must, upon the request of the enrollee or their legal representative, provide such coverage at the facility in which the person resided immediately prior to the hospitalization if:   + The person's primary care physician determines that the medical care needs of the person can be met at the requested facility;   + The requested facility has all applicable licenses and certifications, and is not under a stop placement order that prevents the person's readmission;   + The requested facility agrees to accept payment from the carrier for covered services at the rate paid to similar facilities that otherwise contract with the carrier to provide such services; and   + The requested facility, with regard to the following, agrees to abide by the standards, terms, and conditions required by the carrier of similar facilities with which the carrier otherwise contracts: (i) Utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting that may be required by the carrier.   + "Long-term care facility" or "facility" means a nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.025, or assisted living facility licensed under chapter 18.20 RCW. |  |
| **Injury due to intoxication or narcotics** |  | RCW 48.21.125 | Plan may not deny coverage for treatment of an injury solely because the injury was sustained as a consequence of the enrolled participant’s being intoxicated or under the influence of a narcotic. |  |
| **Mammograms** |  | RCW 48.21.225  WAC 284-50-270 | * Does the contract provide benefits for screening or diagnostic mammography services, where such services are recommended by the patient's physician or advanced registered nurse practitioner? * Plan can apply standard contract provisions applicable to other benefits such as deductible cost sharing. E.g., may apply deductible and copay requirements. |  |
| **Medical Director** |  | RCW 48.43.540 | Does the issuer have a medical director licensed under Chapter 18.57 or 18.71 RCW (i.e., licensed as a D.O. or M.D.)? |  |
| **Medically Necessary Dental Anesthesia** |  | RCW 48.43.185(1)  RCW 48.43.185(2)  RCW 48.43.185(3) | * Whether or not the plan covers dental services, does the contract cover general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such anesthesia services and related facility charges are medically necessary because the covered person:   + Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or   + Has a medical condition that the person's physician determines would place the person at undue risk if the dental procedure were performed in a dental office? (The procedure must be approved by the person's physician.) * If the plan provides dental coverage, does it cover medically necessary general anesthesia services in conjunction with any covered dental procedure performed in a dental office if the general anesthesia services are medically necessary because the covered person is under the age of seven or physically or developmentally disabled? * Issuer may apply cost-sharing,maximum annual limits, and prior authorization to these services; can limit to in-network providers, and negotiate provider rates. |  |
| **Mental Health or Substance Use Disorder**  **(“MH/SUD”)**  **Mental Health or Substance Use Disorder**  **(“MH/SUD”)**  **(Cont’d)**  **Mental Health or Substance Use Disorder**  **(“MH/SUD”)**  **(Cont’d)**  **Mental Health or Substance Use Disorder (“MH/SUD”)**  **(Cont’d)**  **Mental Health or Substance Use Disorder (“MH/SUD”)**  **(Cont’d)** | Benefit  Requirement  Benefit Requirement (Cont’d) | RCW 48.21.180  RCW 48.21.241  RCW 48.21.195  WAC 284-43-991  RCW 48.21.241(2) Mandated Coverage  RCW  48.21.241 (3)  RCW 48.21.242 | * Does the health plan provide SUD benefits by an “approved treatment program” under RCW 70.96A.020(3)? * Does the plan define “Mental Health Services” consistent with WAC 284-43-130(20)?   “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 issuer’s medical director or designee determines the treatment to be medically necessary.”   * Does the plan define Substance Use Disorder consistent with RCW 48.21.195 and WAC 284-43-991?   “Substance use disorder includes illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter [69.50](http://app.leg.wa.gov/RCW/default.aspx?cite=69.50) RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).”   * Does the plan provide mental health services and prescription drugs intended to treat any disorder covered under the definition of mental health services?   + If there is a MOOP or stop loss, it must be a single limit or stop loss for medical, surgical, and mental health services. * 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. * No preauthorization for mental health treatment rendered by a state hospital if the enrollee or covered dependent is involuntarily committed. |  |
| Parity Requirement | P.L. 110-343  Wellstone / Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)  RCW 48.21.241(2)  WAC 284-43-992  WAC  284-43-992(3) | * Does the plan apply any financial requirement or treatment limitation to mental health or substance use disorder benefits that is more restrictive than those applied to medical/surgical benefits? * No separate deductible for mental health benefits. * Does the health plan provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?   + 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.   + In classifying a particular benefit, a plan must apply the same standards to medical/surgical benefits and MH/SUD benefits. An issuer must classify covered intermediate MH/SUD benefits, e.g., residential treatment, partial hospitalization, and intensive outpatient treatment, in the same way that it classifies comparable intermediate medical/surgical benefits. E.g., if a plan classifies skilled nursing facility care as inpatient benefits, then it must also treat residential mental health treatment as inpatient benefits. If home health care is classified as an outpatient benefit, then intensive outpatient mental health or substance use disorder services and partial hospitalization must be classified as outpatient benefits. |  |
| Parity Requirement  (Cont’d)  Parity Requirement  (Cont’d) | WAC  284-43-992(3)  (Cont’d)  WAC  284-43-992(4)  WAC 284-43-993  WAC 284-43-994  WAC  284-43-994(2)  WAC 284-43-992 (6)(c and d)  WAC  284-43-994(1) | * 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:   + Quantitative treatment limitations: expressed numerically (such as fifty outpatient visits per year)   + 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   + 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 * If a health plan or issuer classifies providers into tiers, and varies cost-sharing based on the different tiers, there must not be any financial requirement or treatment limitation on MH/SUD benefits that is more restrictive than what applies to substantially all medical/surgical benefits in that tier. * 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  Prohibited Exclusions  (Cont’d) | WAC  284-43-995(1)  WAC  284-43-995(2)  WAC  284-43-995(3)  WAC  284-43-995(4) | * Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed. * 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. * Benefits for MH/SUD may not be limited or denied based solely on age or condition. * Medically necessary benefits for MH/SUD treatment may not be denied solely because they were court ordered. |  |
| Required Disclosures | WAC 284-43-996 | Does the policy inform enrollees of their rights to free information, including:   * access to and copies of all information relevant to a claim * the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of MH/SUD benefits and apply an NQTL to medical/surgical and MH/SUD benefits under the plan? |  |
| **Neuro-developmental**  **Therapy** |  | O.S.T. v. Regence BlueShield, No. 88940-6 (WN October 9, 2014).  RCW 48.21.310(2)  RCW 48.21.310(3)  RCW 48.21.310(4) | * Does the contract provide benefits for neurodevelopment therapies?   + Must provide benefits for mental health diagnoses (Diagnoses listed in the DSM) without any “blanket limitations” (e.g., age six and under)   + Services covered must include physical, speech, and occupational therapies.   + Benefits shall be payable only where the services have been delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where covered services have been rendered by such licensee.   + Benefits shall be provided to restore and improve function, and for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service.   + Benefits must be for medically necessary services.   + Benefits may not be subject to annual or lifetime dollar limits, but may be subject to visit limits, deductible, cost sharing, and requirements for written treatment plans.   + The contract may not exclude or limit coverage for assessment or testing to determine the amount and type of neurodevelopmental therapy needed. |  |
| **Pharmacy**  **Pharmacy**  **(Cont’d)**  **Pharmacy**  **(Cont’d)** |  | WAC 284-43-822(1)  WAC  284-43-822(2)(a)  WAC  284-43-822(2)(b)  WAC  284-43-822(2)(d)  WAC  284-43-822(2)(e)  WAC 284-43-822(2)(f) | **This section applies only to plans that cover prescription drugs. If the plan does not cover prescription drugs, you can skip this section and go on to the next section, PKU coverage.**   * It is an unfair practice for any carrier to restrict, exclude, or reduce coverage on the basis of sex * Does the plan include include Rx benefits? If yes:   + Must not exclude coverage of prescription drugs and devices including associated medical services for prescribing, dispensing, delivery, distribution, administration and removal of contraceptive devices;   + Benefit waiting period, limitations, or restrictions on Rx contraceptives may not be more restrictive than those required of other Rx benefits   + Carrier may limit to closed formulary but it shall cover each required type   + If excludes coverage for other nonprescription drugs/devices it may also exclude for nonprescription contraceptive drugs/devices   + FDA approved Prescription Contraceptives shall include: Contraceptive Drugs, Barrier methods, and Emergency Contraception   *See, also,* Erickson v. Bartell Drug Co., 141 F. Supp.2d 1266 (W.D. Wash. 2001) |  |
| Coverage | WAC  284-30-450(4)(a)  WAC  284-30-450(4)(b)  WAC  284-30-450(4)(a) | * A carrier cannot exclude a drug solely because of lack of FDA approval for the given use (“off-label” use)   + This includes coverage for medically necessary services associated with the administration of the drug   + Can require the off label use be confirmed by other research studies, reference compendium, or the Federal government |  |
| Pharmacy Statement | WAC 284-43-815 | If the plan includes Rx benefits, does the contract or certificate of coverage contain the “Your right to Safe and Effective Pharmacy Services” statement? |  |
| Oral Anticancer Medication | RCW 48.21.223 | If the plan covers cancer chemotherapy, it must provide coverage for prescribed, self-administered anticancer medication. The plan may use a formulary, require prior auth, or impose other appropriate utilization controls on this coverage, but must cover oral chemo on a basis at least comparable to chemo medications administered by a provider or facility. |  |
| Coordination of Prescriptions | Chapter 213, Laws of 2015 (will be codified in Chapter 48.43 RCW)  48.43.XXX(1)  48.43.XXX(1)(a)  48.43.XXX(1)(b)  48.43.XXX(1)(c)  48.43.XXX(2)  48.43.XXX(2)(a)  48.43.XXX(2)(b)  48.43.XXX(2)(c)  48.43.XXX(3)(a)  48.43.XXX(3)(b) | Issuer must have a prescription synchronization/coordination policy for the dispensing of prescription drugs to the plan's enrollees.   * If an enrollee requests medication synchronization for a new prescription, the health plan must permit filling the drug:   + for less than a one-month supply of the drug if synchronization will require more than a fifteen-day supply of the drug; or   + for more than a one-month supply of the drug if synchronization will require a fifteen-day supply of the drug or less. * The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug subject to coinsurance that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications. * The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug with a copayment that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications by:   + Discounting the copayment rate by fifty percent;   + Discounting the copayment rate based on fifteen-day increments; or   + Any other method that meets the intent of this section and is approved by the office of the insurance commissioner. * Upon request of an enrollee, the prescribing provider or pharmacist shall:   + Determine that filling or refilling the prescription is in the best interest of the enrollee, taking into account the appropriateness of synchronization for the drug being dispensed;   + Inform the enrollee that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing his or her medications; and   + Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse. * "Medication synchronization" means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. * "Prescription" has the same meaning as in RCW 18.64.011. |  |
| Pharmacists – Eye Drop Refills | Chapter 85, Laws of 2015 – To be Codified in Chapter 18.64 RCW | 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:   * The refill is requested by a patient at or after seventy percent of the predicted days of use of   + The date the original prescription was dispensed to the patient; or   + The date that the last refill of the prescription was dispensed to the patient; * The prescriber indicates on the original prescription that a specific number of refills will be needed; and * The refill does not exceed the number of refills that the prescriber indicated. |  |
| **PKU**  **PKU**  **(Cont’d)** |  | RCW 48.21.300(2)  WAC 284-50-260(4)  WAC 284-50-260(4)  WAC 284-50-260(5) and (6)  WAC  284-50-260(3)(e) | * Does the contract provide the formulas necessary for the treatment of PKU?   + Coverage may be limited to the usual and customary charge for such formulas   + Coverage may be subject to deductibles and cost sharing only to the extent that deductibles and cost sharing are applied to general expenses incurred for common sicknesses or disorders under the provisions of the plan.   + May not relate PKU formula to a special expense benefit, such as an RX benefit, unless it results in the PKU formula benefit being paid at an amount no less than benefits for medically necessary treatment for common sicknesses or disorders.   + No increased premiums, preexisting condition provisions, cancellations or nonrenewal due to an enrollee using this benefit or having phenylketonuria. * A contract that provides benefits for hospital services only or for custodial services only may limit the coverage for PKU formulas to formula used during time such services are provided. |  |
| **Prostate Cancer Screening** |  | RCW 48.21.227(1)  RCW 48.21.227(2) | * Each contract that provides coverage for hospital or medical expenses must provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant. * Issuer may apply deductible or copayment provisions applicable to other benefits. |  |
| **Provider**  **Requirements**  **Provider**  **Requirements**  **(Cont’d)**  **Provider**  **Requirements**  **(Cont’d)**  **Provider Requirements (Cont’d)** | Right to choose PCP  (Cont’d) | 42 U.S.C.  §300gg-19a(a)  45 CFR §147.138(a)(1)(i)  RCW 48.43.515(2)  45 CFR §147.138(a)(2)(i)  45 CFR §147.138(a)(3)(i)(B)  45 CFR 147.138(a)(4)(i)  45 CFR 147.138(a)(4)(iii)(A)  45 CFR 147.138(a)(4)(iii)(B)  45 CFR 147.138(a)(4)(iii)(C) | * Does the contract allow the enrollee to choose any PCP who is accepting new enrollees from a list of participating providers? * If the plan requires designation of a PCP, does it allow a child to designate a pediatrician (allopathic or osteopathic) who is in-network and able to accept the child? * Does the plan treat the provision of obstetrical and gynecological care, and the ordering of related services and items, as being authorized by a PCP? * If the plan requires designation of a primary care provider (“PCP”), does the contract inform each enrollee of the terms of the plan regarding designation of a PCP and of their rights?   + May use this model language:     - For plans that require or allow for the designation of primary care providers by enrollees:   “[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].”   * + - For plans that require or allow for the designation of a primary care provider for a child, add:   “For children, you may designate a pediatrician as the primary care provider.”   * + - For plans that provide coverage for obstetric or gynecological care and require the designation by an enrollee of a primary care provider, add:   “You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].” |  |
| Right to Change PCP | RCW 48.43.515 (2)  WAC 284-43-251(1) | Does the contract or certificate of coverage permit changing primary care providers at any time, becoming effective no later than the beginning of the month following the request? |  |
| Continuation Upon Provider Termination | RCW 48.43.515(7)  WAC 284-43-251(5) | * If the plan **is** subject to an open enrollment period, does the contract allow an enrollee whose PCP’s contract is being terminated from the plan to continue care under the terms of the contract until the end of the next open enrollment period? * If the plan **is not** subject to an open enrollment period, does the contract allow an enrollee whose PCP’s contract is being terminated from the plan to continue care under the terms of the contract for at least sixty (60) days following notice of termination to the enrollee? |  |
| Participating Providers | WAC 284-30-130(23)  WAC  284-43-320(2)(a)  WAC  284-43-320(2)(d)  WAC  284-43-320(2)(b)  WAC  284-43-320(2)(c) | * Is the definition of “participating provider” consistent with the statutory and regulatory definitions:   + “Participating provider means a provider, who under a contract with the health carrier or with the carrier’s contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.” * Contract may not contain any provision conflicting with requirement that:   + Participating or in-network Provider may not bill enrollee for covered services except for deductible, co-payments, or coinsurance;     - This includes where issuer denies payment because the provider failed to comply with the terms/conditions of its contract   + In the event of issuer’s insolvency, provider must continue to provide benefits until the later of:     - the end of the policy period for which the enrollee paid premiums; or     - The person’s discharge from inpatient facilities.   + If any conflict between provider contract and health benefit contract, health benefit contract governs. Provider contract may not modify health benefit contract. |  |
| Second Opinion | RCW 48.43.515(6)  WAC 284-43-251(4) | * Each carrier must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice. * Issuer may not impose any charge or cost on the enrollee for the second opinion other than what would be imposed for the same service in otherwise similar circumstances. |  |
| Specialists | RCW 48.43.515(4)  WAC 284-43-229(4) | * Does the contract provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted?   + If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers at in-network rates. |  |
| Specialist Standing Referral | RCW 48.43.515 (3)  WAC 284-43-251(2) | Does the contract or certificate of coverage explain that you may request a standing referral to a specialist for an extended period of time if you have a complex or serious medical or psychiatric condition?   * Must be consistent with the enrollee’s medical or psychiatric needs and plan benefits. |  |
| **Reconstructive breast surgery** |  | RCW 48.21.230(1)  RCW 48.21.230(2)  WHCRA, 29 USC §1185b (a) | * Does the contract provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury?   + Must provide 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.   + Must include all stages of reconstructive surgery on the affected breast, prostheses, and treatment of physical complications of the mastectomy, including lymphedema. |  |
| **Retrospective Denial** |  | RCW 48.43.525 (1) | Carrier cannot retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan’s written policies at the time the care was rendered. |  |
| **Subrogation** |  | Thiringer v. American  Motors Ins.,  91 WN 2d 215, 588 P.2d 191 (1978)  Great West Life Annuity Ins v. Knudson | If the contract includes a subrogation provision, does it:   * Make clear that the issuer is entitled only to excess after the enrollee is fully compensated * Inform enrollee that legal expenses will be apportioned equitably, whether or not recovery is made * 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. |  |
| **Timely Filing** | Standard Master  Contract | WAC 284-43-920 (1)(a) | Was the contract filed before being offered for sale to the public? |  |
| Negotiated  Groups | WAC 284-43-920 (2) | * Was the contract filed within 30 working days of:   + Completion of Group Negotiation, or   + Premium Renewal Date? |  |
| **Unfair and Discriminatory Practices**  **Unfair and Discriminatory Practices**  **(Cont’d)**  **Unfair and Discriminatory Practices**  **(Cont’d)**  **Unfair and Discriminatory Practices**  **(Cont’d)**  **Unfair and Discriminatory Practices**  **(Cont’d)** |  | RCW 48.30.040 RCW 48.30.090 | * No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein. Nor shall the terms of a contract be misrepresented or misleading comparisons be made to induce an member to terminate or retain a contract or membership. |  |
| Discrimination on the basis of a health factor prohibited  In General  Discrimination on basis of health factor prohibited –  In general (Cont’d) | 42 U.S.C.  §300gg-4(a)(6)  45 CFR §146.121(a)(1)  45 CFR §144.103  45 CFR §146.121(a)(2)  45 CFR §146.121(a)(3)  45 CFR §146.117 | * “Health Factor” means, in relation to an individual:    + Health status;   + Medical condition (including both physical and mental illnesses),      - “Medical condition or condition means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.   + Claims experience;   + Receipt of health care;   + Medical history;   + Genetic information,   + Evidence of insurability; or      - “Evidence of Insurability” includes conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.   + Disability. * The decision whether health coverage is elected for an individual (including whether the individual enrolls during special enrollment or late enrollment) is not, itself, within the scope of any health factor. However, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible. |  |
| Discrimination on the basis of a health factor prohibited  In Rules for Eligibility | 42 U.S.C.  §300gg-4 (a)  45 CFR §146.121(b)(1)(i)  42 U.S.C. §300gg-4(a)  45 CFR §146.121(b)(1)(ii)(A)  (B)  (C)  (D)  (E)    (F)    (G)  (H)  45 CFR §146.121(e)(3) | * Prohibited discrimination in rules for eligibility:   + May not have any rule for eligibility (including continued eligibility) of any individual to enroll that discriminates based on any health factor that relates to that individual or a dependent of that individual, subject to the provisions below regarding how this rule applies to benefits, allows establishment of groups of similarly situated individuals, provides for wellness programs, and permits favorable treatment of individuals with adverse health factors.   + Rules for eligibility include, but are not limited to, rules relating to—      - Enrollment;     - The effective date of coverage;     - Waiting (or affiliation) periods;     - Late and special enrollment;     - Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);     - Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing)     - Continued eligibility; and     - Terminating coverage (including disenrollment) of any individual. * A plan or issuer may distinguish in rules for eligibility between full-time and part-time employees, and current and former employees. |  |
| Discrimination on the basis of a health factor prohibited  In Benefits | 45 CFR  §146.121(b)(2)(i)(A)  45 CFR  §146.121(b)(2)(i)(B)  45 CFR  §146.121(b)(2)(i)(C)  45 CFR §146.121(b)(2)(ii) | * Prohibited discrimination in benefits:   + General rule: Issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.   + However, benefits that are provided must be uniformly available to all similarly situated individuals.   + Any restriction on a benefit must apply uniformly to all similarly situated individuals. Must not be directed at individual participants based on any health factor.     - Thus, issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants based on any health factor of the participants.   + Issuer may require the satisfaction of a deductible, or other cost-sharing requirement if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants based on a health factor.   + A plan amendment applicable to all individuals in one or more groups of similarly situated individuals and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.   + Exception for wellness programs:issuer may vary benefits, including cost-sharing, based on whether an individual has met the standards of a wellness program that satisfies the requirements. |  |
| “Source of Injury” exclusions prohibited | 45 CFR §146.121  (b)(2)(iii)(A) | If a plan generally provides benefits for a type of injury, the issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury. |  |
| Discrimination on the basis of a “health factor” prohibited - In premiums or contributions | 42 U.S.C.  §300gg-4 (b)  45 CFR §146.121(c)(1)  42 U.S.C.  §300gg-4 (j)(2-3)  45 CFR §146.121(c)(3)  45 CFR §146.122(b)(1) | * Issuer may not require a person, as a condition of enrollment or continued enrollment in the plan, to pay a premium or contribution greater than that for a similarly situated enrollee in the plan based on any health factor of the individual or a dependent of the individual. This includes discounts, rebates, payments in kind, and any other premium differential mechanisms.   + Exception for wellness programs**:** Issuer may vary the amount of premium or contribution for similarly situated individuals based on whether an individual has met the standards of a wellness program that satisfies the requirements.   + Issuer must not adjust premium or contribution amounts for the plan, or any group of similarly situated individuals under the plan, on the basis of genetic information. |  |
| Treatment of Similarly Situated Individuals | 45 CFR  §146.121 (d)(1)  45 CFR §146.121(d)(2)  45 CFR §146.121(d)(2)(i)(A)    (B)  (C)  (D)  (E)  45 CFR §146.121(d) | * Issuer may treat subscribers as a group of similarly situated individuals separate from dependents.   + Distinction between groups must be based on a bona fide employment-based classification consistent with the employer's usual business practice.   + Whether a classification is bona fide is determined on the basis of all the relevant facts and circumstances, including whether the employer uses the classification for something other than qualification for health coverage     - Examples of bona fide classifications: full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee, and different occupations.     - Classification based on any health factor is not a bona fide employment-based classification, unless it involves favorable treatment of individuals with adverse health factors. * Subscribers may be treated as two or more distinct groups of similarly situated individuals and dependents may be treated as two or more distinct groups of similarly situated individuals.   + if the distinction between or among the groups of dependents is based on any of the following:     - a bona fide employment-based classification of the subscriber through whom the dependent receives coverage;     - Relationship to the subscriber (for example, as a spouse or as a dependent child);     - Marital status;     - With respect to children of a subscriber, age or student status; or     - any other factor if the factor is not a health factor. * If individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package. |  |
| Discrimination directed at individuals | 45 CFR §146.121(d)(3) | **I**f the creation or modification of an otherwise-allowable employment or coverage classification is directed at individual subscribers or dependents based on any health factor of the participants or beneficiaries, the classification is not permitted unless it is more favorable treatment of individuals with adverse health factors. |  |
| Non-confinement and “Actively at Work” Provisions | 45 CFR  §146.121 (e)(1)(i)  45 CFR §146.121(e)(2)(ii) | * Issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on:   + whether an individual is confined to a hospital or other health care institution; or   + an individual's ability to engage in normal life activities, except to the extent permitted to distinguish among employees based on the performance of services; or   + whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work. * Issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence. |  |
| More favorable treatment of individuals with adverse health factors permitted | 45 CFR  §146.121 (g) | Issuer may establish more favorable rules for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. |  |
| **Wellness Programs**  **Wellness Programs**  **(Cont’d)**  **Wellness Programs**  **(Cont’d)**  **Wellness Programs**  **(Cont’d)**  **Wellness Programs**  **(Cont’d)**  **Wellness Programs**  **(Cont’d)**  **Wellness Programs**  **(Cont’d)**  **Wellness Programs**  **(Cont’d)**  **Wellness Programs**  **(Cont’d)** |  | 42 U.S.C. §300gg-4 (j)(1)  45 CFR §146.121 (f)  45 CFR §146.121(f)(1)(i)  42 U.S.C.  §300gg-4 (j)(2)(A-E)  45 CFR §146.121(f)(1)(ii)  42 U.S.C. §300gg-4 (j)(1)(B)  45 CFR §146.121(f)(2)  45 CFR §146.121(f)(1)(ii)(A)  45 CFR §146.121(f)(1)(ii)(B)  45 CFR §146.121(f)(1)(ii)(C)  45 CFR §146.121(f)(1)(ii)(D)  45 CFR §146.121(f)(1)(ii)(E)  45 CFR §146.121(f)(1)(ii)(F)  42 U.S.C. §300gg-4 (j)(3)  45 CFR §146.121(f)(1)(iii)  45 CFR §146.121(f)(1)(iv)  45 C.F.R. §146.121(f)(3)(i)  45 C.F.R. §146.121(f)(3)(ii)  45 C.F.R. §146.121(f)(3)(iii)  45 CFR §146.121(f)(3)(iv)  45 CFR §146.121(f)(3)(iv)(A)  45 CFR §146.121  (f)(3)(iv)(A)(1)  45 CFR §146.121  (f)(3)(iv)(A)(2)  45 CFR §146.121(f)(3)(iv)(B)  45 CFR §146.121(f)(3)(iv)(C)  45 CFR §146.121  (f)(3)(iv)(C)(1)  45 CFR §146.121  (f)(3)(iv)(C)(2)  45 CFR §146.121  (f)(3)(iv)(C)(3)  45 CFR §146.121  (f)(3)(iv)(C)(4)  45 CFR §146.121(f)(3)(iv)(D)  45 CFR §146.121(f)(3)(iv)(E)  45 CFR §146.121(f)(3)(v)  45 CFR §146.121(f)(6)  42 U.S.C. §300gg-4 (j)(3)  45 CFR §146.121(f)(1)(v)  45 CFR §146.121(f)(4)(i)  45 CFR §146.121(f)(4)(ii)  45 C.F.R. §146.121(f)(5)  45 CFR §146.121(f)(4)(iii)  45 CFR §146.121(f)(4)(iv)  45 CFR §146.121(f)(4)(iv)(A)  45 CFR §146.121(f)(4)(iv)(B)    45 CFR §146.121(f)(4)(iv)(C)  45 CFR §146.121  (f)(4)(iv)(C)(1)  45 CFR §146.121  (f)(4)(iv)(C)(2)  45 CFR §146.121  (f)(4)(iv)(C)(3)  45 CFR §146.121  (f)(4)(iv)(C)(4)  45 CFR §146.121(f)(4)(iv)(D)  45 CFR §146.121  (f)(4)(iv)(D)(1)  45 CFR §146.121  (f)(4)(iv)(D)(2)  45 CFR §146.121(f)(4)(iv)(E)  42 U.S.C. §300gg-4 (j)(3)(E))  45 CFR §146.121(f)(4)(v)  RCW 48.43.670 | * “Wellness program” means a program of health promotion or disease prevention. * Issuer may give a reward for similarly situated individuals in connection with a wellness program that satisfies the requirements below. Reward can be a discount or rebate of a premium or contribution, waiver of all or part of a cost-sharing mechanism, the absence of a surcharge, or the value of a benefit the plan would otherwise not provide. This is not considered impermissible discrimination on the basis of a health factor if the wellness program meets the following criteria as either a “participatory wellness program” or a “Health-contingent wellness program.” * A reward based on a “Participatory wellness program” is allowable IF:   + the program is made available to all similarly situated individuals, AND     - none of the conditions for obtaining a reward under the program are based on an individual satisfying a standard that is related to a health factor; OR     - the program does not provide a reward.   + Examples: the following programs are permissible “participatory wellness programs” if participation in the program is made available to all similarly situated individuals:      - A program that reimburses all or part of the cost for memberships in a fitness center;     - A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.     - A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.     - A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.     - A program that provides a reward to employees for attending a monthly health education seminar.     - A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment. (*See also* §146.122 for rules prohibiting collection of genetic information.) * “Health-contingent wellness program”:   + A wellness program is “health-contingent” if any condition for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor. There are 2 types of health contingent wellness programs: activity-only and outcome-based.   + “Activity only” wellness programs require enrollees to perform or complete an activity related to a health factor to get a reward, but not to attain or maintain a specific health outcome.     - Examples: walking, diet, or exercise programs, which some people may be unable to participate in or complete due to a health factor. A reward based on an activity only wellness program is allowable IF:     - Program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.     - The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan. BUT, if, in addition to employees, any class of dependents (e.g., spouses or spouses and dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled.     - Program must be reasonably designed to promote health or prevent disease.       * Must have a reasonable chance of improving the health of or preventing disease in participating individuals       * Must not be overly burdensome       * Must not be a subterfuge for discriminating based on a health factor       * Must not be highly suspect in the method chosen to promote health or prevent disease.     - The reward must be available to all similarly situated individuals.       * Must allow a reasonable alternative standard (or waiver of the otherwise-applicable standard) for obtaining the reward for an individual for whom, for that period:         + it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; OR         + it is medically inadvisable to attempt to satisfy the otherwise applicable standard.       * Reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.       * Whether a plan or issuer has furnished a reasonable alternative standard depends on “all facts and circumstances”, including but not limited to:         + If it is completion of an educational program, the issuer must make the program available or assist the enrollee to find a program (may not require enrollee to find it unassisted). May not require enrollee to pay the cost of the program.         + Time commitment required must be reasonable (e.g., requiring nightly one-hour class is unreasonable).         + If it is a diet program, issuer is not required to pay for the cost of food but must pay any membership or participation fee.         + If enrollee’s physician states that a standard is not medically appropriate for enrollee, issuer must provide a reasonable alternative standard that accommodates the medical appropriateness recommendations of the enrollee’s physician. Issuer may impose standard cost sharing under the plan for medical items and services furnished pursuant to the physician's recommendations.       * To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply in the same manner as if it were an initial program standard. (e.g., if the reasonable alternative standard to a running program is a walking program, individuals who cannot complete the walking program must be provided a reasonable alternative standard to the walking program.) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements for an outcome-based wellness program.       * If reasonable under the circumstances, an issuer may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program. * Issuer must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.   + May use the following sample language, or substantially similar:   “Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.”   * + An “Outcome-based wellness program” requires enrollees to attain or maintain a specific health outcome (e.g., not smoking) to obtain a reward. These wellness programs typically have two tracks to obtaining the reward: achieving the health outcome or, for enrollees who do not attain or maintain the health outcome, compliance with an alternative. Example: a wellness program tests enrollees for high blood pressure and provides a reward to those identified as within a normal or healthy range, while requiring those outside the normal or healthy range (or at risk) to take additional steps (e.g., adhering to a health improvement action plan) to obtain the same reward. A reward based on an “outcome-based wellness program” is allowable IF:     - Enrollees have the opportunity to qualify for the reward under the program at least once per year.     - The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed 30 percent (50% in connection with a program designed to prevent or reduce tobacco use) of the total cost of employee-only coverage under the plan. If dependents may participate in the wellness program, the reward must not exceed 30% (50% if in connection with a program to reduce or prevent tobacco use) of the total cost of the coverage for employee and dependents. The “cost of coverage” means the total amount of employer and employee contributions towards the coverage.     - The program must be reasonably designed to promote health or prevent disease       * Must have a reasonable chance of improving the health of, or preventing disease in, participating enrollees,       * Must not be overly burdensome,       * Must not be a subterfuge for discriminating based on a health factor, and       * Must not be highly suspect in the method chosen to promote health or prevent disease.       * Determination is based on all the relevant facts and circumstances.       * Reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening that is related to a health factor.     - The full reward under the outcome-based wellness program must be available to all similarly situated individuals.       * Reward is not available to all similarly situated individuals unless the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual who does not meet the initial standard based on the health factor measurement.       * Reasonable alternative standard must be furnished upon request or the condition for obtaining the reward must be waived.     - Whether issuer has furnished a reasonable alternative standard based on “all facts and circumstances”, including but not limited to:       * If it is completion of an educational program, issuer must make the program available or help the enrollee find one (instead of making them find it unassisted), and may not require enrollee to pay for the program.       * Time commitment required must be reasonable (e.g., a nightly one-hour class would be unreasonable).       * If it is a diet program, the issuer is not required to pay for the cost of food but must pay any membership or participation fee.       * If an enrollee's physician states that a plan standard is not medically appropriate for that enrollee, the plan or issuer must provide a reasonable alternative standard that accommodates the enrollee’s physician’s medical appropriateness recommendations. Issuers may impose standard cost sharing under the plan for medical items and services furnished pursuant to the physician's recommendations.     - To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements as if it were an initial program standard. To the extent that the alternative standard is, itself, another outcome-based wellness program, it must comply with the requirements for an outcome-based wellness program, subject to the following special rules:       * The alternative standard cannot be a different level of the same standard without additional time to comply that takes into account the individual's circumstances. (e.g., if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. But it could be to reduce BMI by a small amount or small percentage, over a realistic period of time.       * Enrollee must be given the opportunity to comply with the recommendations of the enrollee’s physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness.       * It is not reasonable to seek verification (e.g., a statement from an enrollee’s physician) under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard.         + But, if issuer provides an alternative health factor measurement that involves an activity related to a health factor, then the requirements for activity-only wellness programs apply to that component of the wellness program. Under those rules, the issuer may, if reasonable under the circumstances, seek verification that the alternative activity is unreasonably difficult due to a medical condition or medically inadvisable. (e.g., if an outcome-based wellness program requires participants to maintain a certain healthy weight and provides a diet and exercise program for enrollees who do not meet the target weight, the issuer may seek verification, if reasonable under the circumstances, that a second reasonable alternative standard is needed for an enrollee for whom it would be unreasonably difficult due to a medical condition, or medically inadvisable to attempt to comply, with the diet and exercise program, due to a medical condition.)   + Issuer must disclose in all plan materials describing the terms of an outcome-based wellness program, and in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.     - Can use the sample language above. * Modification of a wellness program upon renewal of a plan does not constitute discontinuation or renewal of that plan.   *Resources*: [ACA FAQ Part V](http://www.dol.gov/ebsa/faqs/faq-aca5.html); [ACA FAQ Part XVIII](http://www.dol.gov/ebsa/faqs/faq-aca18.html) |  |
| **Rescissions Prohibited** | Both Grand-fathered and non-grand-fathered plans | 42 USC § 300gg-12  45 CFR §147.128(a)(1)  45 CFR §147.128(a)(1)  45 CFR §147.128(a)(2)  45 CFR §147.128(a)(2)(i)  45 CFR §147.128(a)(2)(ii) | * Issuer may not rescind coverage with respect to an individual (including a group to which the individual belongs or family coverage under which the individual is included) once the individual is covered, UNLESS:   + Individual (or someone seeking coverage on his behalf) performs an act, practice, or omission that constitutes fraud, or   + Makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. * At least 30 days’ written notice must be provided to each affected participant. * Rescission means cancellation or discontinuance of coverage that has retroactive effect; *e.g*., a cancellation that treats a policy as void from the time of the individual's or group's enrollment, or a cancellation that voids benefits paid up to a year before the cancellation. A cancellation or discontinuance of coverage is not a rescission if:   + The cancellation or discontinuance of coverage has only a prospective effect; or   + The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.   *See, also:* [ACA FAQs Part II](http://www.dol.gov/ebsa/faqs/faq-aca2.html) |  |
| **Standard of Care** |  | RCW 48.43.545 | Issuer may not attempt to waive, shift, or modify its responsibility to adhere to the accepted standard of care for health care providers when arranging for medically necessary health care for enrollees. Issuer is liable for any harm proximately caused by its failure to follow the standard of care when the failure results in denial, delay, or modification of the health care service recommended for, or furnished to, the enrollee. This includes all the issuer’s employees, agents, or ostensible agents. |  |
| **Temporo-mandibular Joint Benefits (Mandated offer)** |  | RCW 48.21.320 (1)  RCW 48.21.320(1)(a)  WAC  284-96-020(1)(a)  WAC  284-96-020(1)  (a)(i), (b)(i) and (c)(i)  WAC  284-96-020(1)  (a)(ii), (b)(ii), and (c)(ii)  WAC  284-96-020(1)(a)(iii), (b)(iii), and (c)(iii)  WAC 284-96-020(3)  RCW 48.21.320(1)(c)  WAC 284-96-020(2) | * Does the group’s application form show that the issuer offered the group optional coverage for the treatment of temporomandibular joint (TMJ) disorders?   + If the plan is medical only, benefits may be limited to medical services related to treatment of TMJ disorders, but cannot define all TMJ disorders as purely dental.   + If the plan is dental only, benefits may be limited to dental services related to treatment of TMJ disorders, but cannot define all TMJ disorders as purely medical.   + Coverage must be generally the same as for other services of that kind (medical, dental), but the plan may require:     - Services to be rendered or referred by the primary care physician or dentist     - A second opinion (but the enrollee must not be responsible for costs for this)     - Preauthorization       * No second opinion or preauthorization can be required for treatment that began within 48 hours (or as soon as reasonably possible) after the occurrence of an accident or trauma to the TMJ     - No discriminatory practices against people submitting TMJ claims or providers who provide services for TMJ within the scope of their licenses   + The benefits can be negotiated (e.g., covered services, medical necessity determinations, provider networks and referral) * The offer of optional coverage must be on the application form(s). If there is no application form, other proof must be kept by the issuer. |  |