# **ANALYST CHECKLIST**

## Disability Carrier – SMALL GROUP STAND ALONE DENTAL PLANS WITH PEDIATRIC EHBs

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

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

* **Note:** For plan years beginning on or after 1/1/2026, the base-benchmark plan for Pediatric Oral Care Essential Health Benefits is the Washington Essential Health Benefits Benchmark Plan approved by the Centers for Medicare and Medicaid Services (CMS) on October 7, 2024. You can access these documents on our website at [https:**//www.insurance.wa.gov**](https://www.insurance.wa.gov)
* **GENERAL REVIEW REQUIREMENTS**

Authority to Review Contract – RCW 48.18.100, RCW 48.43.715, WAC 284-43-5622, 284-43-5642, WAC 284-43-5702

| **Topic** | **Sub-Topic** | **Reference** | **Specific Issue** | **Form # and page or section** | **Additional Information** |
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| **Requirement for Pediatric Oral Services EHB** |  | 42 USC 18022(a)(1) and 42 USC §18022(b)(1)(J);Benchmark plan; WAC 284-43-5400; WAC 284-43-5602; WAC 284-43-5702  | In order to meet the requirements for the “Pediatric Oral Services” Essential Health Benefit, the plan must provide coverage for the oral Services listed in the benchmark plan, in a manner substantially similar to the base benchmark plan, delivered to those under age nineteen. The plan must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age nineteen. |  |  |
| Lifetime and Annual Dollar limits | 42 USC §300gg-11(a); 42 USC §300gg-21(c) | Stand Alone Dental Plans that include family coverage (coverage for those over age 18), as excepted benefits plans, may have lifetime and annual limits, for those over age 18. |  |  |
| Annual Limit on Cost Sharing | 45 CFR 156.150(a) | The annual maximum cost sharing for pediatric EHBs cannot exceed $450 for one child and $900 for multiple children.  |  |  |
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| **Continuation of Care During Enrollee Absence** | Labor Dispute | RCW 48.21.075 | Contract must allow for the employee to pay premiums directly to the contract holder, not to exceed 6 months, in the event that the employee’s compensation is suspended as the result of strike, lock-out or other labor dispute.* Applies whether employer pays all or part of premium
* All three actions (strike, lockout, other labor dispute) must appear in description provisions.
* After the self pay period the employee must be given the opportunity to purchase an individual policy per the RCW.
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| **Congenital Anomalies** | Mandated Benefit | RCW 48.21.155(1) | If contract covers dependents, it must provide coverage from the moment of birth. Coverage shall include, but not to be limited to, coverage for congenital anomalies. |  |  |
|  | Benchmark plan | * Must cover dentally appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Injury or Illness, including cosmetic/reconstructive services.
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| RCW 48.21.155(2) | * If payment of additional premium is required to provide coverage for the child, contract may require notification of birth and payment of the premium within no less than 60 days from date of birth.
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| **Contract Examination and Standards****Contract Examination and Standards (Cont’d)****Contract Examination and Standards (Cont’d)****Contract Examination and Standards (Cont’d)****Contract Examination and Standards (Cont’d)****Contract Examination and Standards (Cont’d)****Contract Examination and Standards (Cont’d)** | Contract Format RequiredContract Format Required (Cont’d) | RCW 48.18.110(1)(a) | Forms must not:* Violate or fail to comply with the Insurance Code or any applicable order or regulation of the Commissioner; or
 |  |  |
| RCW 48.18.110(1)(b) | * Fail to comply with any approved controlling filing; or
 |  |  |
| RCW 48.18.110(1)(c) | * Contain or incorporate by reference 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; or
 |  |  |
| RCW 48.18.110(1)(d) | * have any title, heading, or other indication of their provisions which is misleading.
 |  |  |
| RCW 48.18.110(1)(e) | * Purchase of insurance under the contract must not be solicited by deceptive advertising.
 |  |  |
| RC W 48.18.110(2) | * The benefits provided in the contract must not be unreasonable in relation to the premium charged.
 |  |  |
| RCW 48.18.130(1) | * The contract must contain all required standard provisions
	+ The commissioner may waive the required use of a particular standard provision in a particular insurance contract form if:
 |  |  |
| RCW 48.18.130(1)(a) | * + - he or she finds the provision unnecessary for the protection of the insured, and inconsistent with the purposes of the contract, and
 |  |  |
| RCW 48.18.130(1)(b) | * + - the contract is otherwise approved by him or her.
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| RCW 48.18.130(2) | * Contract must not contain any provision inconsistent with or contradictory to any standard provision used or required to be used.
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|  | * + The Commissioner may approve any provision which is in his or her opinion more favorable to the insured than the standard provision or optional standard provision otherwise required.
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|  | * + Endorsements, riders, or other documents attached to the contract must not vary, extend, or in any respect conflict with any standard provision, or with any modification thereof approved by the Commissioner as being more favorable to the insured.
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| RCW 48.18.130(3) | * In lieu of the required standard provisions, substantially similar standard provisions required by the law of a foreign or alien insurer's domicile may be used when approved by the Commissioner.
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| RCW 48.18.160 | * Forms must not contain any provision purporting to make any portion of the charter, bylaws, or other constituent document of the insurer a part of the contract unless that portion is set forth in full in the contract. Any policy provision in violation of this section shall be invalid.
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| RCW 48.18.190 | * Policy must include the entire contract. No agreement in conflict with, modifying, or extending any contract of insurance shall be valid unless in writing and made a part of the policy.
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| RCW 48.18.200(1) | * Contract must not contain any condition, stipulation, or agreement that:
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| RCW 48.18.200(1)(a) | * + requires the contract to be construed according to the laws of any other state or country; or
 |  |  |
| RCW 48.18.200(1)(b) | * + deprives the courts of this state of the jurisdiction of action against the insurer; or
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| RCW 48.18.200(1)(c) | * + limits right of action against the insurer to a period of less than one year from the time when the cause of action accrues.
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| Exclusions. Limitations, and Reductions | RCW 48.18.140(f);RCW 48.21.080 | * The exceptions, reductions, and limitations must be set forth in the contract either included with the benefit provisions to which they apply, or under an appropriate caption such as "exclusions," "exceptions," or "exceptions and limitations".
* If an exception, reduction, or limitation specifically applies only to a particular benefit under the contract, the statement of such exception, reduction, or limitation must be included with the benefit provision to which it applies.
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| Injury Resulting from Intoxication | RCW 48.21.125 | * The policy cannot exclude services solely because the injury was sustained as a result of the insured being intoxicated or under the influence of a narcotic.
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| Fraud Statement | RCW 48.135.080 | * All applications must contain a statement similar to the following: “It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.”
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| Freedom to Contract for Non-Covered Services | RCW 48.43.085 | * Contract must provide that enrollees are free to contract for services outside the plan on any terms or conditions the enrollees choose.
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| RCW 48.21.147(1)(a) | * Contract may not:
	+ require, directly or indirectly, that a participating provider dentist provide non-covered services to an enrollee at a fee set by, or subject to the approval of, the issuer, including services that would be reimbursable but for the application of contractual limitations (e.g., benefit maximums, deductibles, coinsurance, waiting periods, or frequency limitations), under the applicable group contract or individual contract; or
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|  | * + Prohibit, directly or indirectly, a participating provider dentist from offering or providing enrollees non-covered services on any terms or conditions acceptable to the dentist and the enrolled participant.
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| Plan May Not Discourage Providers from Informing Enrollees | RCW 48.43.510(6) | * Plan must not preclude or discourage providers from:
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|  | * + Informing enrollees of care they require, including treatment options;
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|  | * + Informing enrollees whether, in the providers' view, such care is covered under the plan;
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|  | * + Advocating on behalf of an enrollee with a carrier; or
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| RCW 48.43.510(7) | * + Discussing the comparative merits of different carriers with their providers, even if providers are critical of a carrier.
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| DenturistServices Covered | RCW 48.43.180RCW 48.21.148 | * Plan must not deny benefits for any service performed by a denturist licensed under Chapter [18.30](http://app.leg.wa.gov/RCW/default.aspx?cite=18.30) RCW if the service was within the lawful scope of their license, and the plan would have provided benefits if the service had been performed by a dentist licensed under Chapter [18.32](http://app.leg.wa.gov/RCW/default.aspx?cite=18.32) RCW.
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|  | [RCW](https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/House%20Bills/1683-S.pdf?q=20230227153351) 48.43.745(1)  | Carriers that provide dental only coverage and every health carrier offering dental only coverage in addition to a health plan must permit denturists licensed under chapter 18.30 RCW to provide dental services or care included in their benefits package to the extent that:  |  |  |
|  | RCW 48.43.745(1)(a) | * The provision of such dental services or care is within the health care providers' permitted scope of practice; and
 |  |  |
|  | RCW 48.43.745(1)(b) | * The providers agree to abide by standards related to:
 |  |  |
|  | RCW 48.43.745(1)(b)(i) | * Provision, utilization review, and cost containment of dental services;
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|  | RCW 48.43.745(1)(b)ii) | * Management and administrative procedures; and
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|  | RCW 48.43.745(1)(b)(iii) | * Provision of cost-effective and clinically efficacious dental services.
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|  | RCW 48.43.745(2) | These requirements do not apply to a licensed health care profession regulated under Title 18 RCW when the licensing statute for the profession states that such requirements do not apply. |  |  |
| No Shifting Liability | RCW 48.43.550 | * Contract may not include any provision waiving, shifting, or modifying the carrier’s responsibility to adhere to the accepted standard of care for health care providers under Chapter 7.70 RCW.
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| Notification of Reasons for Particular Actions | RCW 48.18.540 | * Upon written request, the issuer must notify an applicant or enrollee in writing of:
	+ Its reasons for canceling, denying, or refusing to renew the contract; or
	+ any benefits, terms, rates, or conditions of such a contract which are restricted, excluded, modified, increased, or reduced.
* These written communications must be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.
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| Reasonable Medical Management | WAC 284-43-5800(3) | * Plan may include reasonable medical management to control costs, including promoting the use of appropriate, high value preventive services, providers and settings.
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| * + Plan must permit waiver of an otherwise applicable copayment for a service that is tied to one setting but not the preferred high-value setting, if the enrollee's provider determines that it would be medically inappropriate to have the service provided in the lower-value setting. Issuer may still apply applicable in-network requirements.
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| Standing Referral | WAC 284-170-360(3) | * Issuer must have a process for an enrollee with a complex or serious condition may receive a standing referral to a participating specialist for an extended time. The standing referral must be consistent with the enrollee's medical needs and plan benefits. E.g., a one-month standing referral would not satisfy this requirement when the expected course of treatment was indefinite. A referral does not preclude issuer performance of utilization review functions.
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| Second Opinion | WAC 284-170-360(5) | * On enrollee’s request, plan must provide access to a second opinion on any diagnosis or treatment plan from a qualified participating provider of the enrollee's choice. Issuer may not impose any cost upon the enrollee for such second opinion other than the cost imposed for the same service in otherwise similar circumstances.
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| Represen-tations | RCW 48.21.060 | * There shall be a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued; that all statements made by the policyholder or by the individuals insured shall in the absence of fraud be deemed representations and not warranties, and that no statement made by any individual insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such individual or to his or her beneficiary, if any.
 |  |  |
| Payment of Premiums / Grace Period | RCW 48.21.070 | * There shall be a provision that all premiums due under the policy shall be remitted by the employer or employers of the persons insured, by the policyholder, or by some other designated person acting on behalf of the association or group insured, to the insurer on or before the due date thereof with such period of grace as may be specified therein.
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| Certificates of Coverage | RCW 48.21.080 | * There shall be a provision that the insurer shall issue to the employer, the policyholder, or other person or association in whose name such policy is issued, for delivery to each insured employee or enrollee, a certificate setting forth in summary form a statement of the essential features of the insurance coverage, and to whom the benefits thereunder are payable described by name, relationship, or reference to the insurance records of the policyholder or insurer.
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| Fittro v. Lincoln Natl Life Ins Co., 111 Wn.2d 46 (1988). | * If there is a conflict in language between the contract and certificate, the certificate governs.
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| Age Limitations | RCW 48.21.090 | * There shall be a provision specifying the ages, if any, to which the insurance provided therein shall be limited; and the ages, if any, for which additional restrictions are placed on benefits, and the additional restrictions placed on the benefits at such ages.
 |  |  |
| Discretionary Clauses Prohibited | WAC 284-96-012(1) | * Contract may not contain a “discretionary clause” that purports to reserve discretion to a carrier or its designees to interpret the contract or decide eligibility for benefits, or requires deference to such interpretations or decisions.
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| WAC 284-96-012(1)(a) | * Specific prohibited provisions:
	+ That the carrier's interpretation of the terms of the contract is binding;
 |  |  |
| WAC 284-96-012(1)(b) | * + That the carrier's decision regarding eligibility or continued receipt of benefits is binding;
 |  |  |
| WAC 284-96-012(1)(c) | * + That the carrier's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;
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| WAC 284-96-012(1)(d) | * + That there is no appeal or judicial remedy from a claim denial;
 |  |  |
| WAC 284-96-012(1)(e) | * + That deference must be given to the carrier's interpretation of the contract or claim decision; and
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| WAC 284-96-012(1)(f) | * + That the standard of review of a carrier's interpretation of the contract or claim decision is other than a de novo review.
 |  |  |
| WAC 284-96-012(2) | * Contract may include provisions that inform enrollees that, as part of its routine operations, the carrier applies the terms of its contracts for making decisions, including determinations regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.
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| **Coordination of Benefits****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits****(Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)****Coordination of Benefits (Cont’d)** | Disclosure of Coordination |  | **Please note which COB Model is used and proceed to the required COB elements.** | **Model A** | **Model B** |
| WAC 284-51-200 | Each certificate of coverage under a contract that provides for COB must contain a description of the COB provisions.  |  |  |
|  | * Does the contract use the model COB provisions in WAC 284-51-255 Appendix A? **OR**
* Does the contract use the model “plain language description” of COB in WAC [284-51-260](https://apps.leg.wa.gov/wac/default.aspx?cite=284-51-260), Appendix B?
 |  |  |
| GeneralGeneral (Cont’d) | WAC 284-51-200(3) | * Plan need not use the specific words and format provided in WAC 284-51-255 and the plain language explanation in WAC 284-51-260. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred, and that indemnify, provided they do not conflict with the requirements of Chapter 284-51 WAC.
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| WAC 284-51-200(4) |

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| * Plan cannot have a COB provision that permits it to reduce its benefits on the basis that:
	+ Another plan exists and the enrollee did not enroll in that plan;
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| * + A person could have been covered under another plan; or
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| * + A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.
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| WAC 284-51-200(5) | * Plan may not provide that its benefits are "always excess" or "always secondary" except as permitted in Chapter 284-51 WAC.
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| RCW 48.21.200(1) | * A carrier may not administer COB in a way that reduces total benefits payable below an amount equal to 100% of total allowable expenses.
 |  |  |
| WAC 284-51-230(1) | * Any secondary plan must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will a secondary plan 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.
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| WAC284-51-195(1) | * When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.
 |  |  |
| Time Limit | WAC284-51-215(1) | Each issuer must establish time limits for payment of a claim and may not unreasonably delay payment through the application of a coordination of benefits provision. Time limits established by a primary plan must be no less favorable than those contained in WAC 284-170-431.* Primary plans must pay ninety-five percent of clean claims subject to this chapter within thirty calendar days of receipt or of determining they are the primary plan, and must pay all clean claims subject to this chapter within sixty calendar days of receipt or of determining they are the primary plan.
* Any time limit established by a secondary plan that is in excess of thirty days from receipt of a claim, with the primary plan's explanation of benefit information or other primary payment details needed to process the claim, will be considered unreasonable.
* The deadlines established in this subsection may be extended for the length of time a primary or secondary plan must wait for information needed from the provider (e.g., medical records) or from the enrollee (e.g., motor vehicle accident information), in order to adjudicate the claim.
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| Definition of “Plan” for Purposes of COBDefinition of “Plan” for Purposes of COB(Cont’d) | WAC284-51-195(12) | * "Plan" means coverage with which coordination is allowed. Separate parts of a plan provided through alternative contracts intended to be part of a coordinated package of benefits are considered one plan. There is no COB among the separate parts of the plan.
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| WAC284-51-195(12)(a) | * If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying COB. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than this definition.
 |  |  |
| WAC284-51-195(12)(a) | * No plan may use COB, or any provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan in Chapter 284-51 WAC.
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| WAC 284-51-195(12)(b)(i) | * "Plan" includes:
	+ Group or individual contracts or blanket disability contracts;
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| WAC 284-51-195(12)(b)(ii) |

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| * + Closed panel plans or other forms of group or individual coverage;
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| WAC 284-51-195(12)(b)(iii) | * + The medical care components of long-term care contracts, such as skilled nursing care; and
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| WAC 284-51-195(12)(b)(iv) | * + Medicare or other governmental benefits, as permitted by law. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.
 |  |  |
| WAC 284-51-195(12)(c)(i) | * “Plan” does not include:
	+ Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
 |  |  |
| WAC 284-51-195(12)(c)(ii) | * + Accident only coverage;
 |  |  |
| WAC 284-51-195(12)(c)(iii) | * + Specified disease or specified accident coverage;
 |  |  |
| WAC 284-51-195(12)(c)(iv) | * + Limited benefit health coverage, as defined in WAC 284-50-370;
 |  |  |
| WAC 284-51-195(12)(c)(v) |

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| * + 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;
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| WAC 284-51-195(12)(c)(vi) | * + Benefits provided in long-term care insurance policies for nonmedical services, e.g., personal care, adult day care, homemaker services, assistance with ADLs, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
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| WAC 284-51-195(12)(c)(vii) |

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| * + Medicare supplement policies;
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| WAC 284-51-195(12)(c)(viii) |

 | * + A state plan under Medicaid;
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| WAC284-51-195(12)(c)(ix) | * + A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;
 |  |  |
| WAC 284-51-195(12)(c)(x) | * + Automobile insurance policies required by statute to provide medical benefits;
 |  |  |
| WAC284-51-195(12)(c)(xi) | * + Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined at section 3, chapter 267, Laws of 2007.
 |  |  |
| Contract Description of COB | WAC284-51-200(7) | * If a person has met the requirements for coverage under the primary plan, a closed panel plan in secondary position must pay benefits as if the covered person had met the requirements of the closed panel plan. COB may occur during the claim determination period even where there are no savings in the closed panel plan.
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| WAC284-51-195(5) | * "Closed panel plan" means a plan that provides benefits in the form of services primarily through providers employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
 |  |  |
| WAC 284-51-195(1) | * The definition of “allowable expense” should be clear that when coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the allowable expense the secondary plan would have paid if it was primary. A secondary plan must not be required to pay an amount in excess of its maximum benefit plus accrued savings.
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| Rules for Coordination of BenefitsRules for Coordination of Benefits (Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits(Cont’d)Rules for Coordination of Benefits (Cont’d)Rules for Coordination of Benefits (Cont’d) | WAC284-51-205(1)(a) |

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| Contract may not contain any provisions that are inconsistent with or less favorable than these COB rules: |

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| * The primary plan must provide benefits as if the secondary plan did not exist. A plan may only take into consideration benefits provided by another plan when it is secondary to that other plan.
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| WAC 284-51-205(3) | * A plan may only take into consideration benefits provided by another plan when it is secondary to that other plan.
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| WAC284-51-205(1)(b) | * If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must provide benefits as if it were primary when an enrollee uses a nonpanel provider, except for emergency services or authorized referrals provided by the primary plan.
 |  |  |
| WAC284-51-205(1)(c) | * When multiple contracts providing coordinated coverage are treated as a single plan per WAC 284-51-195, the COB rules apply only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the plan, the issuer designated as primary within the plan is responsible for the plan's compliance with Chapter 284-51 WAC.
 |  |  |
| WAC284-51-205(1)(d) | * If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans pay. Each secondary plan must consider the benefits of the primary plan and the benefits of any other plan, which, under the COB rules, has its benefits determined before those of that secondary plan.
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| WAC284-51-205(2)(a) | * Except as provided below, a plan that contains noncompliant COB provisions is always the primary plan unless the provisions of both plans state that the complying plan is primary.
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| WAC284-51-245(2)(a) | * + A plan with order of benefit determination rules that comply with the WAC rules (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary", or that uses order of benefit determination rules inconsistent with the WAC rules (noncomplying plan) on the following basis:
 |  |  |
| WAC284-51-245 (2)(a)(i) | * + - If the complying plan is the primary plan, it must provide its benefits first;
 |  |  |
| WAC284-51-245 (2)(a)(ii) | * + - If the complying plan is the secondary plan under Chapter 284-51 WAC, it must provide its benefits first, but the amount of benefits payable must be determined as if the complying plan were the secondary plan. In this situation, the payment is the limit of the complying plan's liability; and
 |  |  |
| WAC284-51-245 (2)(a)(iii) | * + - * If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within forty-five days after the date on the letter making the request, the complying plan may assume the benefits of the noncomplying plan are identical to its own, and pay its benefits accordingly. If, within twenty-four months after payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it must adjust payments accordingly between the plans.
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| WAC284-51-245 (2)(b) |

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| * + - If the noncomplying plan reduces its benefits so the enrollee receives less in benefits than they would have received had the complying plan provided its benefits as the secondary plan and the noncomplying plan provided its benefits as the primary plan, and governing state law allows the right of subrogation outlined below, then the complying plan may advance to the covered person or on behalf of the covered person an amount equal to the difference.
 |

 |  |  |
| WAC284-51-245 (2)(c) | * + - Complying plan may not advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense. In consideration of the advance, the complying plan is subrogated to all rights of the enrollee against the noncomplying plan. The advance by the complying plan must be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.
 |  |  |
| WAC284-51-205 (2)(b) | * Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. (e.g., major medical coverages superimposed over base plan hospital and surgical benefits, and insurance coverages written in connection with a closed panel plan to provide out-of-network benefits.)
 |  |  |
| WAC 284-51-205(4) | * **Order of benefit determination.** Each plan determines its order of benefits using the first of the following rules that applies:
 |  |  |
| WAC284-51-205 (4)(a)(i) | * + Nondependent or dependent.
		- Subject to the following, the plan that covers the person other than as a dependent (e.g., as an employee, member, subscriber, policyholder or retiree) is the primary plan and the plan that covers the person as a dependent is the secondary plan.
 |  |  |
| WAC284-51-205 (4)(a)(ii) |

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| * + - 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:
 |

 |  |  |
| WAC284-51-205 (4)(a)(ii)(A)(l) | * + - Secondary to the plan covering the person as a dependent; and
 |  |  |
| WAC284-51-205 (4)(a)(ii)(A)(ll) | * + - Primary to the plan covering the person as other than a dependent (e.g., a retired employee);
 |  |  |
| WAC284-51-205 (4)(a)(ii)(B) | * + - * Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.
 |  |  |
| WAC284-51-205(4)(b) | * + **Dependent child covered under more than one plan.** Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits as follows:
 |  |  |
| 284-51-205 (4)(b)(i) | * + - For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 |  |  |
| WAC 284-51-205 (4)(b)(i)(A) | * + - * The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 |  |  |
| WAC 284-51-205 (4)(b)(i)(B) | * + - * If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
 |  |  |
| WAC284-51-205 (4)(b)(ii) |

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| * + - For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 |

 |  |  |
| WAC284-51-205 (4)(b)(ii)(A) | * + - * If a court decree states that one parent is responsible for the dependent child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision;
 |  |  |
| WAC284-51-205 (4)(b)(ii)(B) | * + - * If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 |  |  |
| WAC284-51-205 (4)(b)(ii)(C) | * + - * If a court decree states that both parents are responsible for the dependent child's health care expenses or coverage, the provisions above for parents married or living together determine the order of benefits;
 |  |  |
| WAC284-51-205 (4)(b)(ii)(D) | * + - * If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the dependent child, the above provisions for parents married or living together determine the order of benefits; or
 |  |  |
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| WAC 284-51-205 (4)(b)(ii)(E) |

 | * + - * If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows:
 |  |  |
| WAC 284-51-205(4)(b)(ii)(E)(I) | * + The plan covering the custodial parent, first;
 |  |  |
| WAC 284-51-205 (4)(b)(ii)(E)(II) | * + The plan covering the custodial parent's spouse, second;
 |  |  |
| WAC 284-51-205 (4)(b)(ii)(E)(III) | * + The plan covering the noncustodial parent, third; and then
 |  |  |
| WAC 284-51-205 (4)(b)(ii)(E)(IV) | * + - * + The plan covering the noncustodial parent's spouse, last.
 |  |  |
| WAC284-51-205(4)(b)(iii) | * + - For a dependent child covered under more than one plan of individuals who are not the child’s parents, the order of benefits is determined as if they were the parents of the child.
 |  |  |
|   | * + **Active employee or retired or laid-off employee.**
 |  |  |
| WAC284-51-205(4)(c)(i) | * + - The plan that covers a person as an active employee (neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
 |  |  |
| WAC 284-51-205(4)(c)(ii) | * If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply.
 |  |  |
| WAC 284-51-205(4)(c)(iii) | * This provision also does not apply if the above provisions regarding nondependents and dependents can determine the order of benefits.
 |  |  |
|  | * + **COBRA or state continuation coverage**
 |  |  |
| WAC284-51-205(4)(d)(i) | * + - If a person has coverage provided under COBRA or under a right of continuation under state or federal law, and is covered under another plan, the plan covering him as an employee, member, subscriber or retiree or covering him as a dependent of one of these, is the primary plan and the plan covering that same person under COBRA or under a right of continuation according to state or other federal law is the secondary plan.
 |  |  |
| WAC 284-51-205(4)(d)(ii) | * + - If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 |  |  |
| WAC284-51-205(4)(d)(iii) | * + - This provision also does not apply if the above provisions regarding nondependents and dependents in (a) of this subsection can determine the order of benefits.
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| * **Longer or shorter length of coverage**
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 |  |  |
| WAC284-51-205(4)(e)(i) | * + - If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
 |  |  |
| WAC 284-51-205(4)(e)(ii) |

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| * + To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the enrollee was eligible under the second plan within twenty-four hours after coverage under the first plan ended.
 |

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|  | * + - The start of a new plan does not include:
 |  |  |
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| WAC 284-51-205(4)(e)(iii) (A) |

 | * + - * A change in the amount or scope of a plan's benefits;
 |  |  |
| WAC 284-51-205(4)(e)(iii)(B) | * + - * A change in the entity that pays, provides or administers the plan's benefits; or
 |  |  |
| WAC 284-51-205(4)(e)(iii)(C) | * + - * A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
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| WAC 284-51-205(4)(e)(iv) |

 | * + - The length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date to determine the length of time his coverage under the present plan has been in force.
 |  |  |
| WAC284-51-205(4)(f) | * + - If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.
 |  |  |
| Rules for Secondary Plan PaymentRules for Secondary Plan Payment (Cont’d) | WAC 284-51-230(1) | * In determining the amount to be paid by the secondary plan if the plan wishes to coordinate benefits, the secondary plan must pay an amount that, when combined with the amount paid by the primary plan, the total benefits paid by all plans equal one hundred percent of the total allowable expense for that claim. The secondary carrier must not be required to pay an amount in excess of its maximum benefit plus accrued savings. The enrollee must not be responsible for a deductible amount greater than the highest of the two deductibles.
 |  |  |
| WAC 284-51-230(3) |

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| * + - “Gatekeeper requirements” means any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. (e.g, use of network providers, prior authorization, primary care physician referrals, or other similar case management requirements.) If a plan by its terms contains gatekeeper requirements, AND a person fails to comply with such requirements, and an alternative procedure is not agreed upon between both plans and the covered person:
 |

 |  |  |
| WAC284-51-230(2)(a) | * + If the plan is secondary, all secondary gatekeeper requirements will be waived if the gatekeeper requirements of the primary plan have been met.
 |  |  |
| WAC284-51-230(2)(b) | * + If the primary plan becomes secondary during a course of treatment, the new primary plan must make reasonable provision for continuity of care if one or more treating providers are not in the new primary plan's network.
 |  |  |
| WAC284-51-230(4) | * When a plan is secondary, it may reduce its benefits so the total benefits provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate and record its savings from the amount it would have paid had it been primary, and must use these savings to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period, so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.
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| Required Provisions: |

 |  | **SKIP IF USING MODEL A LANGUAGE** If the plan provides for COB, it must contain provisions substantially as follows: |  |  |
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| “Facility of Payment” |

 | WAC 284-51-220 | * "If payments that should have been made under this plan are made by another plan, the issuer has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. To the extent of such payments, the issuer is fully discharged from liability under this plan."
 |  |  |
| “Right of Recovery” | WAC 284-51-225 | **SKIP IF USING MODEL A LANGUAGE** "The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person, other issuer or plan that has received payment.”  |  |  |
| “Notice to Covered Persons”“Notice to Covered Persons” (Cont’d) | WAC 284-51-235 | * + - The plan must include the following statement in the enrollee contract or booklet provided to covered persons:

"If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days. CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage."  |  |  |
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| If Plans Cannot Agree Which is Primary |

 | WAC 284-51-245(4) | If the plans cannot agree on the order of benefits within thirty calendar days after they have received the information needed to pay the claim, they must immediately pay the claim in equal shares and determine their relative liabilities following payment. No plan is required to pay more than it would have paid had it been the primary plan. |  |  |
|  |  |  |  |  |  |
| **Crown and fixed bridge****Crown and fixed bridge (Cont’d)** | Required CoverageRequired Coverage (Cont’d) | Benchmark plan; WAC 284-43-5702(4)(g). See, also, WAC 284-43-5702(6)  | Plan must cover crown and fixed bridge services in a manner substantially equal to the base benchmark plan including, at a minimum: |  |  |
| Benchmark plan | * Stainless steel crowns for primary posterior teeth once in a three-year period; and
 |  |  |
| Benchmark Plan; WAC 284-43-5702(5)(s)  | * + - * Stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17 and 32) once every three years.
 |  |  |
| Benchmark plan | * Bridges (fixed partial dentures);
	+ Benefits need not be provided for replacement made fewer than seven years after placement.
 |  |  |
| Benchmark plan | * + - * Crowns and crown build-ups, limited to the following:
 |  |  |
| Benchmark plan | * + - * An indirect crown in a five-year period, per tooth, for permanent anterior teeth for Members with fully erupted permanent anterior teeth;
 |  |  |
| Benchmark plan | * + - * Cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;
 |  |  |
| Benchmark plan | * + - * Core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;
 |  |  |
| Benchmark plan | * + - * Recementations of permanent indirect crowns for Members with fully erupted permanent anterior teeth;
 |  |  |
| Benchmark plan | * + - * Dental implant crown and abutment related procedures, one per enrollee per tooth in a seven-year period.
 |  |  |
| Benchmark plan | * Adjustment and repair of dentures and bridges;
	+ Benefits need not be provided for adjustments or repairs done within one year of insertion.
 |  |  |
| Benchmark plan | * Repair of crowns. May be limited to one per tooth; and
 |  |  |
| Benchmark plan | * Repair of implant-supported prosthesis or abutment. May be limited to one per tooth.
 |  |  |
|  |  |  |  |  |  |
| **Diagnostic Services****Diagnostic Services (Cont’d)** | Required Diagnostic Services that Must be Provided Without Cost SharingRequired Diagnostic Services that Must be Provided Without Cost Sharing (Cont’d) | Benchmark plan; WAC 284-43-5702(4)(a). See, also, WAC 284-43-5702(6) | Must cover diagnostic services in a manner substantially equal to the base-benchmark plan. This must include, at least, the following services, which must be covered without cost sharing (as they are covered as preventive services under the base benchmark plan): |  |  |
| Benchmark plan | * + - * Periodic and comprehensive oral examinations, limited to two per Member per Calendar Year, beginning before one year of age;
 |  |  |
| Benchmark plan | * + - * Problem focused oral examinations;
 |  |  |
| Benchmark plan | * + - * Limited visual oral assessments or screenings, not performed in conjunction with other clinical oral evaluation services;
 |  |  |
| Benchmark plan | * + - * Bitewing X rays;
 |  |  |
| Benchmark plan | * + - * Cephalometric films;
 |  |  |
| Benchmark plan | * + - * Panoramic mouth X rays;
 |  |  |
| Benchmark plan | * + - * Occlusal intraoral X rays;
 |  |  |
| Benchmark plan | * + - * Periapical X rays that are not included in a complete series for diagnosis in conjunction with definitive treatment;
 |  |  |
| Benchmark Plan | * + - * Diagnostic casts when dentally appropriate; and
 |  |  |
| Benchmark Plan | * + - * Photographic images (oral and facial) when dentally appropriate.
 |  |  |
|  |  |  |  |  |  |
| **Disclosures** | Health Care Benefit Managers  | WAC 284-180-325(1) | * If the plan utilizes Health Care Benefit Managers, a website link to the list of the Health Care Benefit Managers must be included in the plan for enrollees to access. See definition of “Health Care Benefit Manager in RCW 48.200.020.
 |  |  |
|  | Network Access | WAC 284-170-200(14) | The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee’s condition. |  |  |
|  |  | RCW 48.43.510(1) | A carrier may not offer to sell a plan to an enrollee or to any group representative, agent, employer, or enrollee representative without first offering to provide, and providing upon request, the following information before purchase or selection: |  |  |
|  |  | RCW 48.43.510(1)(g); WAC 284-170-260(1) | * Form should inform enrollees that the current provider directory is posted online and that a printed copy of the current directory is available to an enrollee upon request.
* Provider directories must be updated at least monthly, and must be offered to accommodate individuals with limited-English proficiency or disabilities.
 |  |  |
|  |  | RCW 48.43.510(1)(g) | * A 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. The offer to provide the information must be clearly and prominently displayed on any information provided to any prospective enrollee, group representative, agent, employer, or enrollee representative.
 |  |  |
| **Disclosures****(Cont’d)****Disclosures****(Cont’d)** | Referral and Authorization  | WAC 284-170-200(8) and (14) | * Statement that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of the issuer.
 |  |  |
|  | WAC 284-170-200(8) and (14) | * Description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble to the provider directory for a health plan OR may be included in the summary of benefits and explanation of coverage for the health plan.
 |  |  |
| Provider Tiering | WAC 284-170-330(2) | * If the plan providers or facilities are placed in tiers, and this network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.
 |  |  |
| WAC 284-170-330(3) | * The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits.
 |  |  |
| WAC 284-170-330(4) | * Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or category required to deliver a covered service is not available to the enrollee in the lowest cost-sharing tier of the network.
 |  |  |
| WAC 284-170-330(4)(a) | * + All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.
 |  |  |
| WAC 284-170-330(4)(b) | * + Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.
 |  |  |
| WAC 284-170-330(6) | * Provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in plan documents so as to deceive consumers as to issuer rating practices and their effect on available benefits.
 |  |  |
|  | * When a tiered network is used, issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:
 |  |  |
| WAC 284-170-330(6)(a) | * + The providers and facilities participating in the tiered network;
 |  |  |
| WAC 284-170-330 (6)(b) | * + The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;
 |  |  |
| WAC 284-170-330 (6)(c) | * + The potential for providers and facilities to move from one tier to another at any time; and
 |  |  |
| WAC 284-170-330 (6)(d) | * + The tier in which each participating provider or facility is assigned.
 |  |  |
|  |  |  |  |  |  |
| **Eligibility****Eligibility (Cont’d)** | Domestic Partner Coverage | RCW 48.43.904RCW 48.21.900 | * The terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family must apply equally to state registered domestic partnerships and individuals in state registered domestic partnerships.
 |  |  |
| Coverage of Dependent with developmental or physical disability | RCW 48.21.150 | * Contract which provides that coverage of a dependent child shall terminate upon attainment of a limiting age for dependent children must also provide that coverage will not be terminated due to attainment of limiting age while the child is and continues to be both (1) incapable of self-sustaining employment by reason of developmental or physical disability and (2) chiefly dependent upon the subscriber for support and maintenance.
 |  |  |
| * Issuer may require proof of incapacity and dependency be provided within 31 days of the child's attainment of the limiting age and subsequently. Must not be required more frequently than annually after two years from the child's attainment of the limiting age.
 |  |  |
| Option to Cover Child to Age 26 | RCW 48.21.157 | * If plan covers enrollee’s child, it must offer the option of covering any child under the age of twenty-six.
 |  |  |
| Adopted Child | RCW 48.01.180(1) | * An enrollee’s child shall be considered a dependent child for coverage purposes upon assumption by the enrollee of a legal obligation for total or partial support of the child in anticipation of adoption. Upon the termination of such legal obligations, the child shall not be considered a dependent child.
 |  |  |
| RCW 48.01.180(2); RCW 48.21.280(1) | * Contract must provide coverage for dependent children placed for adoption under the same terms and conditions as apply to the natural, dependent children of the enrollee whether or not the adoption has become final.
 |  |  |
| RCW 48.21.280(2) | * + If payment of an additional premium is required to cover the child, the contract may require notification of placement of a child and payment of the premium within no less than 60 days.
 |  |  |
|  |  |  |  |  |  |
| **Emergency Treatment****Emergency Treatment (Cont’d)** | Requirement to CoverRequirement to Cover(Cont’d) | RCW 48.43.740(1) | * Plan must not deny coverage for treatment of emergency dental conditions that would otherwise be considered a covered service of the contract on the basis that the services were provided on the same day the enrollee was examined and diagnosed for the emergency dental condition.
 |  |  |
| RCW 48.43.740(2)(a) | * + "Emergency dental condition" means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in:
 |  |  |
| RCW 48.43.740(2)(a)(i) | * + - Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;
 |  |  |
| RCW 48.43.740 (2)(a)(ii) | * + - Serious impairment to bodily functions; or
 |  |  |
| RCW 48.43.740 (2)(a)(iii) | * + - Serious dysfunction of any bodily organ or part.
 |  |  |
| Benchmark plan | * Plan must cover emergency treatment for relief of dental pain.
 |  |  |
|  |  |  |  |  |  |
| **Endodontic Treatment****Endodontic Treatment (Cont’d)** | RequiredEndodontic ServicesRequired Endodontic Services (Cont’d) | Benchmark plan; WAC 284-43-5702(4)(e). See, also, WAC 284-43-5702(6)  | Plan must cover endodontic treatment (**not** including indirect pulp capping) in a manner substantially equal to the base benchmark plan including, at a minimum: |  |  |
| Benchmark Plan | * Apexification for apical closures of anterior permanent teeth;
 |  |  |
| Benchmark Plan | * Apicoectomy;
 |  |  |
| Benchmark Plan | * Debridement;
 |  |  |
| Benchmark Plan | * Direct pulp capping;
 |  |  |
| Benchmark Plan | * Pulpal therapy;
 |  |  |
| Benchmark Plan | * Pulp vitality tests;
 |  |  |
| Benchmark Plan | * Pulpotomy; and
 |  |  |
| Benchmark Plan | * Root canal treatment.
 |  |  |
|  |  |  |  |  |  |
| **Every category of Provider** | No separately-Priced Benefit | WAC 284-170-270(5) | * Issuers may not offer coverage for services by certain categories of providers solely as a separately-priced optional benefit (e.g., chiropractic care; acupuncture).
 |  |  |
| Services Performed by RN or ARNP | RCW 48.21.141 | * Contract must cover services performed by a Registered Nurse or Advanced Registered Nurse Practitioner if:
 |  |  |
|  | * + the service is within the scope of the provider’s license, and
 |  |  |
|  | * + The contract would have covered the service if it had been performed by a physician licensed under Chapter 18.71 RCW.
 |  |  |
| Denturist | RCW 48.21.148;RCW 48.43.180 | Denturist must be able to provide services within the scope of their license if the plan would provide the same benefits performed by a dentist.  |  |  |
|  |  |  |  |  |  |
| **Experimental or Investi-gational****Treatment****Experimental or Investi-gational** **Treatment (Cont’d)** | Definition Must be Included | WAC 284-96-015(1) | * If the contract includes exclusion, reduction or limitation for services that are experimental or investigational, contract must include a definition of Experimental and Investigational services.
 |  |  |
| WAC 284-96-015(2) | * + The definition must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational.
 |  |  |
|  | * + - If the carrier or an affiliated entity is the authority making the determination, it must state the criteria it will utilize to make the determination. This requirement may be satisfied by using one or more of the following statements, or other similar statements:
 |  |  |
| WAC 284-96-015(2)(a) | * + - * "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."
 |  |  |
| WAC284-96-015(2)(b) | * + - * "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."
 |  |  |
| WAC284-96-015(2)(b) | * + The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.
 |  |  |
| WAC 284-43-3110(1);WAC 284-96-015(3) | * Whether the claim or request for preauthorization is made in writing or through other claim presentation or preauthorization procedures set out in the contract, any denial because of an experimental or investigational exclusion or limitation, must be done in writing within twenty working days of receipt of a fully documented request. The issuer may extend the review period beyond twenty days only with the informed written consent of the enrollee.
 |  |  |
| Appeal Requirements | WAC 284-96-015(4)(a) | Every group disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that: |  |  |
| WAC 284-96-015 (4)(a)(i) | * A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. Insurer may extend the review period beyond 20 days only with the informed written consent of the covered individual;
 |  |  |
| WAC 284-96-015 (4)(a)(ii) | * The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and
 |  |  |
| WAC 284-96-015 (4)(a)(iii) | * The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.
 |  |  |
| WAC 284-96-015(4)(b) | When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth: |  |  |
| WAC 284-96-015 (4)(b)(i) | * The basis for denial of benefits or refusal to preauthorize services; and
 |  |  |
| WAC 284-96-015 (4)(b)(ii) | * The name and professional qualifications of the person or persons reviewing the appeal.
 |  |  |
| WAC284-96-015(4)(c) | Disclosure of the existence of an appeal procedure shall be made by the insurer in each policy and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation. |  |  |
|  |  |  |  |  |  |
| **Home and Facility Visits** |  | Benchmark plan | Home visits, including extended care facility calls. May be limited to two calls per facility per provider. |  |  |
|  |  |  |  |  |  |
| **Medically Necessary Orthodontia** |  | Benchmark Plan; WAC 284-43-5702(4)(i). See, also, WAC 284-43-5702(6)  | Plan must cover medically necessary orthodontia in a manner substantially equal to the base benchmark plan including, at a minimum: |  |  |
| Benchmark Plan | * Medically Necessary orthodontia for malocclusions associated with:
 |  |  |
| Benchmark Plan | * + cleft lip and palate, cleft palate and cleft lip with alveolar process involvement; and
 |  |  |
| Benchmark Plan | * + craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, arthrogryposis or Marfan syndrome.
 |  |  |
|  |  |  |  |  |  |
| **Non-Discrimin-ation** | Non-Discrimination Notice | RCW 48.43.0128; WAC 284-43-5980(1)  | The issuer must file a Non Discrimination Notice to include:   |  |  |
| **Non-Discrimin-ation (Cont’d)** | Non-Discrimination Notice (Cont’d) | WAC 284-43-5980(1)(a) | * That the issuer does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation in its benefits and services;
 |  |  |
|  |  | 45 CFR § 92.102(b); WAC 284-43-5980(1)(b) | * The issuer provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities;
 |  |  |
|  |  | 45 CFR § 92.101(2); WAC 284-43-5980(1)(c) | * The issuer provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency; and
 |  |  |
|  |  | WAC 284-43-5980(1)(d) | * How to obtain these aids and services; and
 |  |  |
|  |  | WAC 284-43-5980(1)(e) | * Identify and provide contact information for the employee responsible for compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980; and
 |  |  |
|  |  | WAC 284-43-5980(1)(f) | * How to file a grievance with the issuer related to the issuers compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980; and
 |  |  |
|  |  | WAC 284-43-5980(1)(g) | * Identify the office of the insurance commissioner as the designated entity to file a complaint regarding compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980 and the federal Department of Health and Human Services, Office of Civil Rights as the designated entity to file a complaint regarding compliance related to the issuer's compliance with 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act). Until that date, issuers may continue to use the sample notice published at 81 Fed. Reg. 31472 through 31473 (May 18, 2016).
 |  |  |
|  |  | WAC 284-43-5980(4) | Taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States. |  |  |
| **Non-Discrimin-ation (Cont’d)** | Non-Discrimination Notice (Cont’d) | WAC 284-43-5980(7) | Contract must include, in a conspicuously visible font size, notice of the requirements shown in WAC 284-43-5980(1) and (4); and  |  |  |
| WAC 284-43-5980(7)(a)(i) | This notice must be included in;* Significant publications and significant communications targeted to enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;
 |  |  |
|  |  | WAC 284-43-5980(7)(a)(ii) | * In conspicuous physical locations where the issuer interacts with the public; and
 |  |  |
|  |  | WAC 284-43-5980(7)(a)(iii) | * In a conspicuous location on the issuer's website accessible from the home page of the issuer's website.
 |  |  |
| WAC 284-43-5980(8) | In significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. |  |  |
|  |  | WAC 284-43-5980(9) | An issuer may combine the content of the notice required in WAC 284-43-5980(1) with the content of the other notices required in WAC 284-43-5980 if the combined notice clearly informs individuals of their rights under RCW [48.43.0128](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.0128) and WAC [284-43-5935](http://app.leg.wa.gov/WAC/default.aspx?cite=284-43-5935) through 284-43-5980 and 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act). |  |  |
|  |  |  |  |  |  |
| **Required Offer of TMJ Coverage****Required Offer of TMJ Coverage (Cont’d)****Required Offer of TMJ Coverage (Cont’d)****Required Offer of TMJ Coverage (Cont’d)** | Temporo-mandibular Joint Disease (TMJ) Mandated Group OfferingMandated Offering (Cont’d) | WAC 284-96-020; RCW 48.21.320 | Offer to contract must include offer of optional coverage for the treatment of temporomandibular joint disorders. |  |  |
| RCW 48.21.320(1)(a) | * Insurers offering dental coverage only may limit benefits to dental services related to treatment of temporomandibular joint disorders, but must not define all temporomandibular joint disorders as purely medical in nature.
 |  |  |
| RCW 48.21.320(1)(b) | * Groups are not required to accept this coverage – issuers may also offer and sell plans with lesser or no TMJ coverage.
 |  |  |
| RCW 48.21.320(1)(c) | * Issuers and groups may negotiate TMJ benefits and coverage. Insurance Code promotes broad flexibility in potential benefit coverage such as: services to be reimbursed, determination of treatments to be considered medically necessary, systems through which services are to be provided, including referral systems and use of other providers, and related issues.
 |  |  |
| 48.21.320(3); WAC 284-96-020(5) | * Requirement to offer TMJ coverage does not apply to group disability policies exempted by RCW [48.21.320](http://app.leg.wa.gov/RCW/default.aspx?cite=48.21.320)(3) [self-insured small groups], or other applicable law.
 |  |  |
| WAC 284-96-020(1)(b) | * One of the offerings must provide benefits as follows:
 |  |  |
| * + coverage for dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and
 |  |  |
| * + a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments.
 |  |  |
| * + Other than the benefit amount, coverage for dental services shall be the same as are generally provided in the policy for other injuries or dental conditions.
 |  |  |
| WAC 284-96-020(1)(b)(i) | * The coverage provisions may require:
	+ That services either be rendered or referred by the covered individual's primary care dentist; and
 |  |  |
| WAC 284-96-020(1)(b)(ii) | * + A second opinion, provided that the enrollee must not be financially responsible for any costs relating to this second opinion
		- these costs may not be counted against the required benefit levels; and
 |  |  |
| WAC 284-96-020 (1)(b)(iii) | * + Prenotification or Preauthorization.
 |  |  |
|  | * + **Except that**: the coverage provisions must not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.
 |  |  |
| Issuer Must Keep Written Record of Offer | WAC 284-96-020(2) | * Required offer of optional TMJ coverage must be included on the group insurer's application form(s); or
 |  |  |
|  | * + If there is no written application form, the group insurer must retain other written evidence of the offer of TMJ coverage, but only if the group has actually purchased coverage.
 |  |  |
|  | * These records must be retained by the insurer for five years or until the completion of the next examination of the insurer by the Insurance Commissioner, whichever occurs first.
 |  |  |
| DiscriminationProhibited | WAC 284-96-020(3) | * Issuer must not discriminate against persons submitting claims for TMJ coverage, or providers who provide TMJ services within the scope of their licensure.
	+ Issuer may limit coverage to participating providers.
 |  |  |
| Required Definition of “Temporo-mandibular Joint Disorders” | WAC 284-96-020(4)(a) | The following definitions must apply and must be contained in the contract (not required to be verbatim):* "Temporomandibular joint disorders" must include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.
 |  |  |
| Required Definition of “Medical Services” | WAC 284-96-020(4)(b)(i) | * "Medical Services" are those which are:
	+ Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
 |  |  |
| WAC 284-96-020(4)(b)(ii) | * + Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
 |  |  |
| WAC 284-96-020(4)(b)(iii) | * + Recognized as effective, according to the professional standards of good medical practice; and
 |  |  |
| WAC 284-96-020(4)(b)(iv) | * + Not experimental or primarily for cosmetic purposes.
 |  |  |
| Required Definition of “Dental Services” | WAC 284-96-020(4)(c)(i) | * "Dental services" are those which are:
	+ Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
 |  |  |
| WAC 284-96-020(4)(c)(ii) | * + Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
 |  |  |
| WAC 284-96-020(4)(c)(iii) | * + Recognized as effective, according to the professional standards of good dental practice; and
 |  |  |
| WAC 284-96-020 (4)(c)(iv) | * + Not experimental or primarily for cosmetic purposes.
 |  |  |
|  |  |  |  |  |  |
| **Oral Surgery****and Re-construction****Oral Surgery and Re-construction (Cont’d)** | Required ServicesRequired Services (Cont’d) | Benchmark plan | Plan must cover oral surgery and reconstruction in a manner substantially equal to the base-benchmark plan including, at a minimum: |  |  |
| Benchmark plan | * Frenulectomy or frenuloplasty;
 |  |  |
| Benchmark plan | * Uncomplicated oral surgery procedures including removal of teeth, incision and drainage;
 |  |  |
| Benchmark plan | * Complex oral surgery procedures including surgical extractions of teeth, impactions, alveoloplasty, vestibuloplasty, and residual root removal;
 |  |  |
| RCW 48.43.715(1); Benchmark plan | * General dental anesthesia or intravenous sedation administered:
	+ In connection with extractions of partially or completely bony impacted teeth;
 |  |  |
| RCW 48.43.185 (1)(b) | * + To safeguard the Member’s health;
 |  |  |
| RCW 48.43.185 (1)(a)  | * + For a covered procedure performed in a dental office if medically necessary because a child is under seven years of age or physically or developmentally disabled.
 |  |  |
| RCW 48.43.185(3) | * + Benefit may be subject to cost sharing, benefit maximums, or prior authorization, and limited to in-network providers.
 |  |  |
| Benchmark plan | * Drugs and/or medications when used with parenteral conscious sedation, deep sedation, or general anesthesia;
 |  |  |
| Benchmark plan | * Inhalation of nitrous oxide, once per day;
 |  |  |
| Benchmark Plan | * Local anesthesia and regional blocks, including office-based oral or parenteral conscious sedation, deep sedation or general anesthesia; and
 |  |  |
| Benchmark planRCW 48.43.185(3) | * Post-surgical complications.
* Plan may apply cost-sharing requirements, and prior authorization requirements to the services or from covering only those services performed by a health care provider, or in a health care facility, that is part of its provider network.
 |  |  |
| Definition of “General Anesthesia Services” | RCW 48.43.185(5) | * For the purpose of this section “general anesthesia services” means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.
 |  |  |
| Allowable exclusion | Benchmark Plan | * Base benchmark plan specifically excludes oral surgery to treat a fractured jaw, and orthognathic surgery.
 |  |  |
|  |  |  |  |  |  |
| **Periodontics** | Required Periodontic Services | Benchmark plan; WAC 284-43-5702(4)(f). See, also, WAC 284-43-5702(6) | Plan must cover periodontic services in a manner substantially equal to the base benchmark plan including, at a minimum: |  |  |
| Benchmark plan | * Periodontal scaling and root planing once per quadrant per Member in a two-year period;
 |  |  |
| Benchmark plan | * Periodontal maintenance once per quadrant in a calendar year;
 |  |  |
| Benchmark plan | * Complex periodontal procedures (osseous surgery including flap entry and closure and mucogingivalplastic surgery);
 |  |  |
| Benchmark plan | * Debridement; and
 |  |  |
| Benchmark plan | * Gingivectomy and gingivoplasty limited to once per enrollee per quadrant in a three-year period.
 |  |  |
|  |  |  |  |  |  |
| **Pharmacy****Pharmacy (Cont’d)****Pharmacy (Cont’d)****Pharmacy (Cont’d)****Pharmacy (Cont’d)****Pharmacy (Cont’d)** |  |  | **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, Preventive Services.** |  |  |
| No Retracting Authori-zation | RCW 48.21.325 | * An issuer may not retract an authorization issued by any means on a pharmacy claim.
 |  |  |
| Statement Required | WAC 284-43-5170(4) | * Contract must include “YOUR PRESCRIPTION DRUG RIGHTS” statement.
 |  |  |
| Allowed Cost Control Measures | WAC 284-43-5080(1) | * Prescription benefit may include cost control measures, including requiring preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition.
 |  |  |
| WAC 284-43-5080(2) | * A carrier may include elements in its prescription drug benefit design that, where clinically feasible, create incentives for the use of generic drugs, e.g. step therapy protocols, use of drug tiering, or otherwise limiting the benefit to the use of a generic drug in lieu of brand name drugs, subject to a substitution process.
 |  |  |
| Required drug substitution processRequired drug substitution process(Cont’d)Required drug substitution process (Cont’d)Required substitution process (Cont’d) | WAC 284-43-5080(3) | * Carrier must establish a process for a provider and enrollee (or their designee) to request a substitution for a prescribed therapy, drug or medication that is not on the formulary.
 |  |  |
| WAC 284-43-5080(3)(a) | * + Process must not unreasonably restrict enrollee's access to nonformulary or alternate medications for conditions that are not responsive to treatment.
 |  |  |
| WAC 284-43-5080(3)(b) | * + For and individual or small group plan, a carrier must make its determination on a standard exception and notify the enrollee or the enrollee’s designee and the prescribing provider of its coverage determination no later than seventy-two hours following receipt of the request. A carrier that grants a standard exception request must provide coverage of the nonformulary drug for the duration of the prescription, including refills.
 |  |  |
| WAC 284-43-5080(3)(c) | * + A carrier must have a process for an enrollee, the enrollee’s designee, or the enrollee’s prescribing provider (or other prescriber) to request an expedited review based on exigent circumstances. “Exigent circumstances” exist when an enrollee is experiencing a health condition that may seriously jeopardize the enrollee’s life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
 |  |  |
| WAC 284-43-5080(3)(c)(i) | * + - A carrier must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee’s designees and the prescribing provider of its coverage determination no later than twenty-four hours following receipt of the request.
 |  |  |
| WAC 284-43-5080(3)(c)(ii) | * + - A carrier that grants an exception based on exigent circumstances must provide coverage of the nonformulary drug for the duration of the exigency.
 |  |  |
| WAC 284-43-5080(3)(d) | * + Subject to the terms and conditions of the policy that otherwise limit or exclude coverage, the carrier must permit substitution of a covered generic drug or formulary drug if:
 |  |  |
| WAC 284-43-5080(3)(d)(i) | * + - An enrollee does not tolerate the covered generic or formulary drug; or
 |  |  |
| WAC 284-43-5080(3)(d)(ii) | * + - Enrollee's provider determines that the covered generic or formulary drug is not therapeutically efficacious for an enrollee; or
 |  |  |
| WAC 284-43-5080(3)(d)(ii) | * + - * Carrier may require the provider to submit specific clinical documentation as part of the substitution request.
 |  |  |
| WAC 284-43-5080(3)(d)(iii) | * + - The provider determines that a dosage is required for clinically efficacious treatment that differs from a carrier's formulary dosage limitation for the covered drug.
 |  |  |
| WAC 284-43-5080(3)(d)(iii) | * + - * Carrier may require the provider to submit specific clinical documentation as part of the substitution request and must review that documentation prior to making a decision.
 |  |  |
| WAC 284-43-5080(4) | * Carrier may require preauthorization for prescription drugs and its substitution process, based on accepted peer reviewed clinical studies, FDA black box warnings, the fact that the drug is available over-the-counter, objective and relevant clinical information about the enrollee's condition, specific medical necessity criteria, patient safety, or other criteria that meet an accepted, medically applicable standard of care.
 |  |  |
| WAC 284-43-5080(4)(a) | * + Neither the substitution process criteria nor the type or volume of documentation required to support a substitution request may be unreasonably burdensome to the enrollee or provider.
 |  |  |
| WAC 284-43-5080(4)(b) | * + Substitution process must be administered consistently and include a documented consultation with the prescribing provider prior to denial of a substitution request.
 |  |  |
| WAC 284-43-5080(5) | * Use of a carrier's substitution process is not a grievance or appeal pursuant to RCW [48.43.530](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.530) and [48.43.535](http://app.leg.wa.gov/RCW/default.aspx?cite=48.43.535). Denial of a substitution request is an adverse benefit determination, and an enrollee, their representative provider or facility, or representative may request review of that decision using the carrier's appeal or adverse benefit determination review process.
 |  |  |
| WAC 284-43-5080(6) | If a carrier denies a request for a standard exception or for an expedited exception, the carrier must have a process for the enrollee, the enrollee’s designee, or the enrollee’s prescribing provider to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. |  |  |
| WAC 284-43-5080(6)(a) | * A carrier must determine whether or not to grant an external exception request review and notify the enrollee or the enrollee’s designee and the prescribing provider of its decision no later than seventy-two hours following its receipt of the request, if the original request was a standard exception request, no later than twenty-four hours following its receipt of the request, if the original request was an expedited exception request.
 |  |  |
| WAC 284-43-5080(6)(b) | * If a standard exception request is granted after an external review, the health plan must provide coverage of the nonformulary drug for the duration of the prescription. If an expedited exception request is granted after an external review, the health plan must provide coverage of the nonformulary drug for the duration of the exigency. If such an exigency ceases, any drug previously covered under such exigency may only be reauthorized through the standard exception request process.
 |  |  |
| Formulary ChangesFormulary Changes (Cont’d) | WAC 284-43-5100 | * Issuer is not required to use a formulary as part of its prescription drug benefit design. If it does, the issuer must, at a minimum, comply with these requirements when a formulary change occurs:
 |  |  |
| WAC 284-43-5100(1) | * + Must not exclude or remove a medication from its formulary if the medication is the sole prescription medication option available to treat a disease or condition for which the plan otherwise provides coverage, unless the medication is removed because it becomes available over-the-counter, is proven to be medically inefficacious, or for documented medical risk to patient health.
 |  |  |
| WAC 284-43-5100(2) | * + If a drug is removed from a formulary for a reason other than withdrawal of the drug from the market, availability of the drug over-the-counter, or the issue of black box warnings by the FDA, issuer must continue to cover the drug for the time period required for an enrollee who is taking the medication at the time of the formulary change to use the substitution process to request continuation of coverage for the removed medication, and receive a decision through that process, unless patient safety requires swifter replacement.
 |  |  |
| WAC 284-43-5100(3) | * + Formularies and related preauthorization information must be posted on an issuer or issuer's contracted pharmacy benefit manager web site and must be current. Unless the removal is done on an immediate or emergency basis or because a generic equivalent becomes available without prior notice, formulary changes must be posted thirty days before the effective date of the change. In the case of an emergency removal, the change must be posted as soon as practicable, without unreasonable delay.
 |  |  |
| Cost Sharing for Substitute DrugsCost Sharing for Substitute Drugs (Cont’d) | WAC 284-43-5110(1) | * Issuer may not charge an ancillary charge, in addition to the plan's normal copayment or coinsurance requirements, for a drug that is covered because of one of the circumstances set forth in either WAC 284-43-5080 or 284-43-5100. An ancillary charge is any charge in addition to or excess of cost-sharing.
 |  |  |
| WAC 284-43-5110(2) | * When an enrollee requests a formulary brand name drug in lieu of a therapeutically equivalent generic drug or a drug from a higher tier, and there is no clinical basis for the substitution, carrier may require enrollee to pay the difference in price between the drug that the formulary would have required, and the covered drug, in addition to the copayment. This charge must reflect the actual cost difference.
 |  |  |
| WAC 284-43-5110(3) | * When carrier approves a substitution drug, whether or not the drug is in the formulary, enrollee's cost-sharing must be adjusted to reflect any discount agreements or other pricing adjustments for the substitution drug available to carrier. Any charge to the enrollee for a substitution drug must not increase carrier's underwriting gain for the plan beyond that calculated for the original formulary drug.
 |  |  |
| WAC 284-43-5110(4) | * If plan uses a tiered formulary, and a formulary substitute drug is required based on WAC 284-43-5080 or 284-43-5100, enrollee's cost sharing may be based on the tier of the substitute drug.
 |  |  |
| WAC 284-43-5110(5); WAC 281-170-470 | * If a carrier requires cost-sharing for enrollees receiving an emergency fill as defined in WAC 284-170-470, then issuers must disclose that information to enrollees within their policy forms. A clear statement explaining that members may be eligible to receive an emergency fill for prescription drugs under the circumstances described in WAC 284-170-470 must be disclosed. This disclosure must include the process that members use to obtain an emergency fill, and cost-sharing requirements, if any, for an emergency fill. The applicable WAC also does not limit the fill to one per prescription medication per calendar year. – WAC 284-43-5110(5), WAC 284-43-5170 (1)(c), and WAC 284-170-470(8)(c).
 |  |  |
| WAC 284-43-5110(6) | * For individual and small group plans, if a substitution is granted, the carrier must treat the drug as an essential health benefit, including by counting any cost-sharing towards the plan’s annual limitation on cost-sharing and towards any deductible.
 |  |  |
|  |  |  |  |  |  |
| **Preventive Services** | Required Preventive Services | WAC 284-43-5702(4)(b). See, also, WAC 284-43-5702(6); WAC 284-43-5800(4) | Plan must cover preventive care services in a manner substantially equal to the base-benchmark plan including, at a minimum: |  |  |
| Benchmark Plan | * Cleanings;
 |  |  |
| Benchmark Plan | * Periodic and comprehensive oral examinations;
 |  |  |
| Benchmark Plan; WAC 284-43-5642 (6)(a)(iv)  | * Fluoride;
 |  |  |
| Benchmark Plan | * Topical fluoride treatments when dentally appropriate;
 |  |  |
| Benchmark Plan | * Sealants; and
 |  |  |
| Benchmark Plan | * Oral hygiene instruction if not billed on the same day as a cleaning.
 |  |  |
| Benchmark Plan | * Installation of space maintainers (fixed unilateral or fixed bilateral), including:
 |  |  |
| Benchmark Plan;WAC 284-43-5702 (5)(t)(i) | * + Recementation of space maintainers;
 |  |  |
| Benchmark Plan;WAC 284-43-5702 (5)(t)(ii) | * + Removal of space maintainers; and
 |  |  |
| Benchmark Plan;WAC 284-43-5702 (5)(t)(iii) | * + Replacement space maintainers when dentally appropriate.
 |  |  |
|  |  |  |  |  |  |
| **Prior Authorization** |  | WAC 284-43-2050(2) | * A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use evidence-based clinical review criteria as outlined in WAC 284-43-2050, which includes a method for reviewing and updating clinical review criteria.
* A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. A carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program.
 |  |  |
|  |  | WAC 284-43-2050(3) | * A prior authorization program must meet standards set forth by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and Accreditation Association for Ambulatory Health Care in addition to the requirements of [WAC 284-43-2050](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-2050) and [WAC 284-43-2060](http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-2060).
* A prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.
 |  |  |
|  | Transparency of Standards and Criteria | RCW 48.43.016(1) | * If the plan imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession, the contract must inform enrollees which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.
 |  |  |
| **Prior Authorization****(Cont’d)** |  | RCW 48.43.016(3) | * Carrier must post on its web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions.
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| Issuer must Consult with Licensed Provider | RCW 48.43.016(4) | * Provider with whom a carrier consults regarding a decision to deny, limit, or terminate a person's covered services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the provider being reviewed or of a specialty whose practice entails the same or similar covered service.
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| No Required Discounts | RCW 48.43.016(5) | * Carrier may not require a provider to provide a discount from usual and customary rates for services not covered under a plan to which the provider is a party.
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| **Prostho-dontic Services (Removable)** | Required Prosthodontic Services | Benchmark Plan; WAC 284-43-5702(4)(h). See, also, WAC 284-43-5702(6)  | Plan must cover removable prosthodontics and prosthodontic-related procedures in a manner substantially equal to the base benchmark plan including, at a minimum: |  |  |
| Benchmark Plan | * One resin-based partial denture, replaced once within a three-year period;
 |  |  |
| Benchmark Plan | * One complete upper and lower denture, and one replacement denture after at least five years from the seat date;
 |  |  |
| Benchmark Plan | * Denture rebase, limited to one per Member per arch in a three-year period, if performed at least six months from the seating date;
 |  |  |
|  | Benchmark plan | * Occlusal guards; and
 |  |  |
|  | Benchmark plan | * Adjustment and repair of dentures and bridges;
	+ Benefits need not be provided for adjustments or repairs done within one year of insertion.
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| **Provider Require-****ments** | Participating Provider Definition | WAC 284-170-130(23) | * “Participating provider” must be defined (whether or not this definition is set forth in the policy) consistent with the statutory and regulatory definitions:
	+ "’Participating provider’ means a facility or 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.”
 |  |  |
| Services by RN or ARNP | RCW 48.21.141 | * Issuer must not deny benefits for services performed by a registered nurse or advanced registered nurse under Chapter [18.79](http://app.leg.wa.gov/RCW/default.aspx?cite=18.79) RCW if the service performed was within the lawful scope of their license, and the contract would have provided benefits if the service had been performed by a licensee under Chapter [18.71](http://app.leg.wa.gov/RCW/default.aspx?cite=18.71) RCW.
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| **Restorative Services** | Required Services | Benchmark plan; WAC 284-43-5702(4)(c) See, also, WAC 284-43-5702(6)  | Plan must cover restorative care in a manner substantially equal to the base benchmark plan, including at least the following services: |  |  |
| Benchmark plan; WAC 284-43-5702(5)(l)  | Plan must cover composite and amalgam restorations (fillings) on the same tooth, limited to once in a two-year period. |  |  |
| Allowable limitations | Benchmark plan | Plan may limit restorations to the following:* Maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars;
 |  |  |
|  | * Maximum of six surfaces per tooth for teeth one, two, three, 14, 15 and 16;
 |  |  |
|  | * Maximum of six surfaces per tooth for permanent anterior teeth; and
 |  |  |
|  | * Two occlusal restorations for the upper molars on teeth one, two, three, 14, 15 and 16.
 |  |  |
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| **Standard of Care**  |  | RCW 48.43.545 | Issuer may not attempt to waive, shift, or modify its responsibility to adhere to the accepted standard of care for health care providers when arranging for medically necessary health care for enrollees. Issuer is liable for any harm proximately caused by its failure to follow the standard of care when the failure results in denial, delay, or modification of the health care service recommended for, or furnished to, the enrollee. This includes all the issuer’s employees, agents, or ostensible agents.(Note RCW 48.43.545 is applicable to a dental plan because of the definition of "Health Care Provider" under 7.70.020(1) (referenced in 48.43.545(1)), the definition of "provider" under RCW 48.43.005(30), and the definition of "health care service" under RCW 48.43.005(31). |  |  |
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| **Subrogation** |  | Thiringer v. American Motors Ins., 91 WN 2d 215, 588 P.2d 191 (1978), Mahler v. Szucs  | If the policy includes a subrogation provision, it must: * 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.

The policy may not:* Have any provision which would inappropriately require full reimbursement for all medical expenses;
* The contract cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.
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| **Unfair and Discrimina-tory Practices****Unfair and Discrimin-atory Practices (Cont’d)** | False Advertising | RCW 48.30.040 | * The forms may not contain any false, deceptive, or misleading representation or advertising relative to the business of a disability insurer or to any person engaged therein.
 |  |  |
| Misrepresen-tation of ContractTerms | RCW 48.30.090 | * The forms may not contain any misrepresentation of the terms of any contract, or the benefits or advantages promised thereby, or use the name or title of any contract or class of contract misrepresenting the nature thereof.
 |  |  |
| No guarantee of future payments | RCW 48.30.100 | * Contract must not guarantee or agree to the payment of future dividends or future refunds of unused premiums or savings.
 |  |  |
| Discrimination Prohibited | RCW 48.30.300 | * No Issuer may refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation as defined in RCW [49.60.040](http://app.leg.wa.gov/RCW/default.aspx?cite=49.60.040), or the presence of any disability of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any disability of the insured or prospective insured.
 |  |  |
| Injury due to Intoxication or narcotics | RCW48.21.125 | * Plan must not deny coverage for treatment of an injury solely because the injury was caused by the enrolled participant's being intoxicated or under the influence of a narcotic.
 |  |  |
| Cost Sharing LevelsCost Sharing Levels(Cont’d) | WAC 284-43-5800(5) | * If plan has cost-sharing structures or tiers for EHBs, they must not be discriminatory.
 |  |  |
| WAC 284-43-5800(5)(a) | * + Plan must not apply cost-sharing or coverage limitations differently to enrollees with chronic disease or complex underlying medical conditions than to other enrollees, unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs, without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan.
 |  |  |
| WAC 284-43-5800(5)(b) | * + Plan must not establish a different cost-sharing structure or tier for a benefit than is applied to the plan in general if the sole type of enrollee who would access that benefit or benefit tier is one with a chronic illness or medical condition.
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