**RCW 48.41.110 Policy coverage—Eligible expenses, cost containment, limits—Explanatory brochure.** (1) The pool shall offer one or more care management plans of coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. The pool may incorporate managed care features into existing plans.

(2) The administrator shall prepare a brochure outlining the benefits and exclusions of pool policies in plain language. After approval by the board, such brochure shall be made reasonably available to participants or potential participants.

(3) The health insurance policies issued by the pool shall pay only reasonable amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of covered illnesses, injuries, and conditions. Eligible expenses are the reasonable amounts for the health care services and items for which benefits are extended under a pool policy.

(4) The pool shall offer at least two policies, one of which will be a comprehensive policy that must comply with RCW 48.41.120 and must at a minimum include the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, including no less than a total of one hundred eighty inpatient days in a calendar year, and no less than thirty days inpatient care for alcohol, drug, or chemical dependency or abuse per calendar year;

(b) Professional services including surgery for the treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

(c) No less than twenty outpatient professional visits for the diagnosis or treatment of alcohol, drug, or chemical dependency or abuse rendered during a calendar year by a state-certified chemical dependency program approved under *chapter 70.96A RCW, or by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not less than one hundred days in a calendar year as prescribed by a physician;

(f) Services of a home health agency;

(g) Chemotherapy, radioisotope, radiation, and nuclear medicine therapy;

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

(k) Durable medical equipment which has no personal use in the absence of the condition for which prescribed;

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery including at least the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth

salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Maternity care services;

(o) Services of a physical therapist and services of a speech therapist;

(p) Hospice services;

(q) Professional ambulance service to the nearest health care facility qualified to treat the illness or injury;

(r) Mental health services pursuant to RCW 48.41.220; and

(s) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition.

(5) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

(6) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. No limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

(7)(a) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services or benefits for outpatient prescription drugs. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection (8) of this section.

(b) The pool shall not impose any preexisting condition waiting period for any person under the age of nineteen.

(8)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

(b) The pool shall waive any preexisting condition waiting period for a person who is an eligible individual as defined in section

2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(9) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(10) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate. The pool may encourage the use of shared decision making and certified decision aids for preference-sensitive care areas. [2012 c 211 s 25; 2011 c 315 s 6. Prior: 2007 c 259 s 26; 2007 c 8 s 5; 2001 c 196 s 4; 2000 c 80 s 2; 2000 c 79 s 13; 1997 c 231 s 213; 1987 c 431 s 11.]

***Reviser's note:** Chapter 70.96A RCW was repealed and/or recodified in its entirety pursuant to 2016 sp.s. c 29 ss 301, 601, and 701.

**Effective date—2011 c 315 ss 5 and 6:** See note following RCW 48.41.100.

**Intent—2011 c 315:** See note following RCW 48.43.005.

**Subheadings not law—2007 c 259:** See note following RCW 7.70.060.

**Effective date—2007 c 8:** See note following RCW 48.20.580.

**Effective date—2001 c 196:** See note following RCW 48.20.025.

**Effective date—Severability—2000 c 79:** See notes following RCW 48.04.010.

**Short title—Part headings and captions not law—Severability—Effective dates—1997 c 231:** See notes following RCW 48.43.005.