

WAC 284-43-8010 Standard disclosure form for short-term limited duration medical plans.

(1) All carriers offering or issuing a short-term limited duration medical plan with an effective date on or after January 1, 2019, must issue a standard disclosure form for each short-term limited duration medical plan in the same format and with the same content as the disclosure form included in this section. The standard disclosure form must be displayed prominently in the medical plan contract and in any application materials provided in connection with enrollment in such coverage, and must be provided as a distinct, separate document to the person upon initial receipt of the medical plan application.

(2) Every carrier must have a mechanism in place to verify delivery of the standard disclosure form to the applicant and obtain the applicant's acknowledgment of receipt of the form. The carrier must retain each acknowledged disclosure form for five years. The forms must be available for review by the commissioner upon request.

(3) The type size and font of the standard disclosure form must be easily read and be no smaller than fourteen point.

(4) The standard disclosure form must not be used until it has been filed with and approved by the commissioner.

(5) The standard disclosure form must include, at a minimum, the following information and must be presented in the following format:

(Carrier's name and address)

**IMPORTANT INFORMATION
ABOUT THE LIMITS OF THE
COVERAGE
YOU ARE BEING OFFERED**

Save this document! It may be important to you in the future.

CAUTION:

This plan may not cover pre-existing conditions, including any medical or mental health condition you've been treated for in the past.

It provides limited benefits and does *not* include benefits required by the Affordable Care Act.

It's temporary and may not cover your costs for most hospital or other medical services, or some essential health benefits.

Read carefully what the plan does and doesn't cover before you sign up.

Before enrolling, check to see if you can buy a health plan through Washington State's Exchange, at www.wahealthplanfinder.org or 1-855-923-4633. If so, you may get help lowering your premium. Health plans sold through the Exchange provide more coverage and protections. If you missed the annual open enrollment period, see if you qualify for a special enrollment period here: www.insurance.wa.gov/when-can-i-buy-individual-health-plan

This medical plan is not a Medicare supplement plan.

This medical plan is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your medical plan carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder serv-

ices). Your medical plan might also have lifetime and/or annual dollar limits on health benefits.

This disclosure form is not a complete description of this medical plan. To understand what is and isn't covered, please read your plan. The plan will include information about your rights and the company's responsibilities.

Short-Term Limited Duration Medical Plan Disclosure

Below is a summary of the key benefits provided by this short-term limited duration medical plan:

Type of coverage: Short-term limited duration medical plan

How long does coverage last? (Provide the number of days or months of coverage)

Does this policy cover pre-existing conditions? ("Yes" or "No, it limits/excludes coverage for medical or behavioral health conditions for which medical advice, diagnosis, care or treatment was received by or recommended to you, including taking prescription medication, in the 24 months prior to the date you apply for coverage under the plan. See policy for details.").

Who is NOT eligible for coverage? (List all excluded categories, e.g. over a certain age, Medicare/Medicaid eligible, pregnant women, those with certain preexisting conditions, etc.)

Can the policy be renewed? No

What benefits are covered and what is the financial responsibility of the member? (For each benefit listed below, if not covered, list "Not covered". If covered, list applicable cost-sharing, including whether or not the deductible applies, the member's percentage of coinsurance, copayment, any quantitative treatment limitations and any cap on the amount the policy will pay for the service.

Examples include: "Covered after deductible, \$45 copay plus 20% coinsurance, limited to only \$1,000 of coverage"; "Covered without deductible, \$50 copay, limited to 30 visits total or per year"; "Covered after deductible, limited to treatment of involuntary complications of pregnancy")

- **Deductible:** \$_____ (If there is more than one deductible, list each deductible with a description of the services to which it applies.)
- **Plan coinsurance (amount member must pay per service)** _____% (Must be expressed in terms of the percentage to be paid by the member. If coinsurance applies up to a maximum amount, provide that information here. Example: "This policy has a 50% coinsurance up to \$10,000, after which benefits are paid at 100%.")
- **The maximum amount a member will pay out-of-pocket for cost-sharing for the term of the plan:** \$_____ (If there is no out-of-pocket maximum, clearly state that there is no limit on the amount a member will have to pay for out-of-pocket cost-sharing. If there is an out of pocket maximum, clearly state which member payments are applied to this maximum, such as deductibles, copayments and coinsurance.)
- **The maximum dollar amount this plan will pay:** \$_____ (Also include lifetime limit, if applica-

ble. Example: "\$1 Million under this plan; lifetime limit of \$2 Million")

- **Emergency Room Services:**
- **Ambulance Services:**
- **Inpatient Hospital Services:**
- **Outpatient Hospital Services:**
- **Services at an Urgent Care Facility:**
- **Primary Care Visit to Treat an Injury or Illness:**
- **Specialist Visit:**
- **Physical therapy, speech therapy, occupational therapy:**
- **Mental Health Outpatient Services**
- **Mental Health Inpatient Services**
- **Substance Use Disorder Outpatient Services:**
- **Substance Use Disorder Inpatient Services;**
- **Imaging (CT/PET Scans, MRIs):**
- **Laboratory testing and services:**
- **Durable medical equipment:**
- **Preventive Care/Screening/Immunization:**
- **Prescription drugs:**
- **Skilled Nursing Facility:**
- **Services in an Ambulatory Surgical Center:**

Does the policy exclude, eliminate, restrict, reduce, limit, or delay coverage for any benefits NOT listed above? ("No" or if "Yes", include details)

Does the policy require that the member use a specific network of health care providers or pharmacies? ("No" or if "Yes", include details)

Can a member be charged additional costs for covered services, in addition to their coinsurance or copays? (If members can be balance billed for any covered service, answer "Yes" and explain when this would occur. You must answer "Yes" for plan designs that do not use a provider network, or that use in-network facilities where not all services may be provided by in-network providers. If other situations apply, include any further explanation about when balance billing is possible.)

If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. This coverage is **not** considered comprehensive and would not qualify you for a special enrollment period.

Open enrollment for individual health plans begins November 1 each year for coverage that begins January 1 of the upcoming year.

You will need to complete and confirm all medical information you provide when applying for this plan. Your producer (also referred to as insurance agent) is not allowed to fill out any of this information for you.

Consumer acknowledgment:

I confirm that I have reviewed the content of this disclosure form and that I understand the limitations of this short-term limited-duration medical plan.

Consumer signature/name: _____

Date: _____

This notice has important information about this short-term limited duration medical plan. If you, or someone you're helping, has questions about this document or complaints about this medical plan and how it was sold to you, call the Washington State Office of the Insurance Commissioner at 1-800-562-6900. If you need help speaking to us in your preferred language, we will find an interpreter for you at no cost.

[Statutory Authority: RCW 48.43.005(26), 48.02.060, 48.44.050, and 48.46.200. WSR 18-21-116, § 284-43-8010, filed 10/17/18, effective 11/17/18.]