RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Office of the Insurance Commissioner

Permanent Rule Only

Effective date of rule:

Permanent Rules

☐ **31 days after filing.**

☒ **Other (specify) upon filing** **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Reason: The U.S. Department of Health and Human Services (HHS) is requiring states to finish updating their Essential Health Benefits rules by autumn. The Office of the Insurance Commissioner implemented an emergency rule (R 2015-01) in May to designate a base-benchmark plan, but that rule has recently expired and needs replacement to keep the state in compliance with HHS regulations.

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ **Yes** ☒ **No** **If Yes, explain:**

Insurance Commissioner Matter No. R 2015-02

Purpose:

The U.S. Department of Health and Human Services ("HHS") decided to extend the base-benchmark approach for establishing Essential Health Benefit coverage levels through at least plan year 2017. As part of this process, HHS required each state to identify a new base-benchmark plan and to update its Essential Health Benefits rule, which applies to fully-insured small group and individual health plans. (continued on Attachment A)

Citation of existing rules affected by this order:

Repealed:

Amended: WAC 284-43-865, -877, -878, -879, and -880

Suspended:

Statutory authority for adoption: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR **15-16-122** on August 5, 2015.

Describe any changes other than editing from proposed to adopted version:

- In 284-43-8781(5)(b)(ii), the agency deleted the reference to the DSM-IV, replacing it with a reference to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM); (continued on Attachment A)

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

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Date adopted: September 29, 2015

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 29, 2015
TIME: 1:48 PM

WSR 15-20-042

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	0	Amended	0	Repealed	0
Federal rules or standards:	New	5	Amended	5	Repealed	0
Recently enacted state statutes:	New	0	Amended	0	Repealed	0

The number of sections adopted at the request of a nongovernmental entity:

	New	0	Amended	0	Repealed	0

The number of sections adopted in the agency's own initiative:

	New	0	Amended	0	Repealed	0

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	5	Amended	5	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New	5	Amended	5	Repealed	0
Pilot rule making:	New	0	Amended	0	Repealed	0
Other alternative rule making:	New	0	Amended	0	Repealed	0

Attachment A to R2015-02 CR 103

Purpose (continued):

To comply with these requirements, the Office of the Insurance Commissioner ("OIC") identified a new base-benchmark plan in May 2015 through emergency rule-making.

This rule finalizes the new base-benchmark plan selection and makes necessary changes to the Essential Health Benefits rule to bring the rule into compliance with changes that have occurred since the OIC originally adopted it in 2013. These changes include but are not limited to:

- Adding language that says that health plans must cover medically-necessary services for transgender individuals;
- Updating the definition of "habilitative services" to more closely fit the new federal definition; and
- Adding language that says that health plans must know and comply with the federal guidance related to the Essential Health Benefits, such as the ACA FAQs that are jointly issued by HHS, the U.S. Department of Labor and the U.S. Department of the Treasury.

To implement these changes, the OIC amended WACs 284-43-865, -877, -878, -879, and -880, adding language stating that these WACs expire on December 31, 2016. The OIC created new sections of the WAC (284-43-8651, -8771, 8781, 8791 and 8801) that will apply to plans that have an effective date on or after January 1, 2017.

PERMANENT RULE (Including Expedited Rule Making):

Describe any changes other than editing from proposed to adopted version: (continued)

- In 284-43-8781(5)(b)(ii), the agency deleted the reference to gender identity disorder, replacing it with a reference to gender dysphoria;
- In 284-43-8781(5)(c), the agency deleted the words "a home health setting in;"
- In 284-43-8781(9)(d), the agency added "In accordance with Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed in this section under paragraph 9(b) (i) to (iv) that are provided in-network."

AMENDATORY SECTION (Amending WSR 12-19-099, filed 9/19/12, effective 10/20/12)

WAC 284-43-865 Essential health benefits package benchmark reference plan. A not grandfathered individual or small group health benefit plan offered, issued, amended or renewed on or after January 1, 2014, must, at a minimum, include coverage for essential health benefits. "Essential health benefits" means all of the following:

(1) The benefits and services covered by health care service contractor Regence ((~~Blue Shield~~)) BlueShield as the *Innova* small group plan policy form, policy form number WW0711CCONMS, and certificate form number WW0112BINNS, offered during the first quarter of 2012. The SERFF filing number is RGWA-127372701.

(2) The services and items covered by a health benefit plan that are within the categories identified in Section 1302(b) of PPACA including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care, and as supplemented by the commissioner or required by the secretary of the U.S. Department of Health and Human Services.

(3) Mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011.

(4) This section expires on December 31, 2016.

NEW SECTION

WAC 284-43-8651 Essential health benefits package benchmark reference plan. A nongrandfathered individual or small group health benefit plan offered, issued, amended or renewed on or after January 1, 2017, must, at a minimum, include coverage for essential health benefits. "Essential health benefits" means all of the following:

(1) The benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* + small group plan, policy form number WW0114CCONMSD and certificate form number WW0114BPPO1SD, offered during the first quarter of 2014. The SERFF form filing number is RGWA-128968362.

(2) The services and items covered by a health benefit plan that are within the categories identified in Section 1302(b) of PPACA including, but not limited to:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management;

(j) Pediatric services, including oral and vision care; and

(k) Other services as supplemented by the commissioner or required by the secretary of the U.S. Department of Health and Human Services.

(3) Mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011.

(4) This section applies to health plans that have an effective date of January 1, 2017, or later.

AMENDATORY SECTION (Amending WSR 14-06-069, filed 3/3/14, effective 4/3/14)

WAC 284-43-877 Plan design. (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2014, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-878, 284-43-879, and 284-43-880.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2014, until December 31, 2016, an issuer must offer the EHB-benchmark plan without substituting benefits for the benefits specifically identified in the EHB-benchmark plan.

(b) For plan or policy years beginning on or after January 1, 2017, an issuer may substitute benefits to the extent that the actuarial value of the benefits in the category to which the substituted benefit is classified remains substantially equal to the EHB-benchmark plan.

(c) "Substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category supports a determination by the commissioner that the benefit is a meaningful health benefit;

(ii) The aggregate actuarial value of the benefits across all essential health benefit categories does not vary more than a de minimis amount from the aggregate actuarial value of the EHB-benchmark base plan; and

(iii) Within each essential health benefit category, the actuarial value of the category must not vary more than a de minimis amount from the actuarial value of the category for the EHB-benchmark plan.

(2) An issuer must classify covered services to an essential health benefits category consistent with WAC 284-43-878, 284-43-879, and 284-43-880 for purposes of determining actuarial value. An issuer may not use classification of services to an essential health benefits category for purposes of determining actuarial value as the basis for denying coverage under a health benefit plan.

(3) The base-benchmark plan does not specifically list all types of services, settings and supplies that can be classified to each essential health benefits category. The base-benchmark plan design does not specifically list each covered service, supply or treatment. Coverage for benefits not specifically identified as covered or excluded is determined based on medical necessity. An issuer may use this plan design, provided that each of the essential health benefit categories

is specifically covered in a manner substantially equal to the EHB-benchmark plan.

(4) An issuer is not required to exclude services that are specifically excluded by the base-benchmark plan. If an issuer elects to cover a benefit excluded in the base-benchmark plan, the issuer must not include the benefit in its essential health benefits package for purposes of determining actuarial value. A health benefit plan must not exclude a benefit that is specifically included in the base-benchmark plan.

(5) An issuer must not apply visit limitations or limit the scope of the benefit category based on the type of provider delivering the service, other than requiring that the service must be within the provider's scope of license for purposes of coverage. This obligation does not require an issuer to contract with any willing provider, nor is an issuer restricted from establishing reasonable requirements for credentialing of, and access to, providers within its network.

(6) Telemedicine or telehealth services are considered provider-type services, and not a benefit for purposes of the essential health benefits package.

(7) Consistent with state and federal law, a health benefit plan must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs including, but not limited to, a chronic condition caused by illness or injury, either acquired or congenital.

(8) Unless an age based reference limitation is specifically included in the base-benchmark plan or a supplemental base-benchmark plan for a category set forth in WAC 284-43-878, 284-43-879, or 284-443-880, an issuer's scope of coverage for those categories of benefits must cover both pediatric and adult populations.

(9) A health benefit plan must not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status;

(b) The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful health benefit; or

(c) The benefit has a discriminatory effect in practice, outcome or purpose in relation to age, present or predicted disability, and expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity or in the application of Section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference based limitations pursuant to WAC 284-43-878, 284-43-879, and 284-43-880.

(11) This section expires on December 31, 2016.

NEW SECTION

WAC 284-43-8771 Plan design. (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2017, must provide coverage that is substantially

equal to the EHB-benchmark plan, as described in WAC 284-43-8781, 284-43-8791, and 284-43-8801.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2017, an issuer must offer the EHB-benchmark plan without substituting benefits for the benefits specifically identified in the EHB-benchmark plan.

(b) "Substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category supports a determination by the commissioner that the benefit is a meaningful health benefit;

(ii) The aggregate actuarial value of the benefits across all essential health benefit categories does not vary more than a de minimis amount from the aggregate actuarial value of the EHB-benchmark base plan; and

(iii) Within each essential health benefit category, the actuarial value of the category must not vary more than a de minimis amount from the actuarial value of the category for the EHB-benchmark plan.

(2) An issuer must classify covered services to an essential health benefits category consistent with WAC 284-43-8781, 284-43-8791, and 284-43-8801 for purposes of determining actuarial value. An issuer may not use classification of services to an essential health benefits category for purposes of determining actuarial value as the basis for denying coverage under a health benefit plan.

(3) The base-benchmark plan does not specifically list all types of services, settings and supplies that can be classified to each essential health benefits category. The base-benchmark plan design does not specifically list each covered service, supply or treatment. Coverage for benefits not specifically identified as covered or excluded is determined based on medical necessity. An issuer may use this plan design, provided that each of the essential health benefit categories is specifically covered in a manner substantially equal to the EHB-benchmark plan.

(4) An issuer is not required to exclude services that are specifically excluded by the base-benchmark plan. If an issuer elects to cover a benefit excluded in the base-benchmark plan, the issuer must not include the benefit in its essential health benefits package for purposes of determining actuarial value. A health benefit plan must not exclude a benefit that is specifically included in the base-benchmark plan.

(5) An issuer must not apply visit limitations or limit the scope of the benefit category based on the type of provider delivering the service, other than requiring that the service must be within the provider's scope of license for purposes of coverage. This obligation does not require an issuer to contract with any willing provider, nor is an issuer restricted from establishing reasonable requirements for credentialing of and access to providers within its network.

(6) Telemedicine or telehealth services are considered a method of accessing services, and are not a separate benefit for purposes of the essential health benefits package. Issuers must provide essential health benefits consistent with the requirements of (add RCW citation for SSB 5175 when it becomes available).

(7) Consistent with state and federal law, a health benefit plan must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs including, but not limited to, a chronic condition caused by illness or injury, either acquired or congenital.

(8) Benefits under each category set forth in WAC 284-43-8781, 284-43-8791, or 284-43-8801 must be covered for both pediatric and adult populations unless:

(a) A benefit is specifically limited to a particular age group in the base-benchmark plan and such limitation is consistent with state and federal law; or

(b) The category of essential health benefits is specifically stated to be applicable only to the pediatric population, such as pediatric oral services.

(9) A health benefit plan must not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status;

(b) The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful health benefit; or

(c) The benefit has a discriminatory effect in practice, outcome or purpose in relation to age, present or predicted disability, and expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity or in the application of Section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted under WAC 284-43-8781, 284-43-8791, and 284-43-8801.

(11) This section applies to health plans that have an effective date of January 1, 2017, or later.

AMENDATORY SECTION (Amending WSR 14-15-012, filed 7/3/14, effective 7/3/14)

WAC 284-43-878 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services." For purposes of determining a plan's actuarial value, an issuer must classify as ambulatory patient services medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and outpatient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiology, professional surgical services, and surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category.

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth, but not excluding services or appliances necessary for or resulting from medical treatment if the service is:

(A) Emergency in nature; or

(B) Requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease. Oral surgery related to trauma and injury must be covered.

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Nonskilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them, other than for cochlear implants, which are covered, and for hearing screening tests required under the preventive services category, unless coverage for these services and devices are required as part of, and classified to, another essential health benefits category;

(viii) Obesity or weight reduction or control other than covered nutritional counseling.

(c) The base-benchmark plan establishes specific limitations on services classified to the ambulatory patient services category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan limits nutritional counseling to three visits per lifetime, if the benefit is not associated with diabetes management. This lifetime limitation for nutritional counseling is not part of the state EHB-benchmark plan. An issuer may limit this service based on medical necessity, and may establish an additional reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days' respite care on either an inpatient or outpatient basis for hospice patients, per lifetime;

(iv) One hundred thirty visits per calendar year for home health care.

(e) State benefit requirements classified to this category are:

(i) Chiropractic care (RCW 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530);

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services." For purposes of determining a plan's actuarial value, an issuer must classify care and services related to an emergency medical condition to the emergency medical services category, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room and department-based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not specifically exclude services classified to the emergency medical care category.

(c) The base-benchmark base plan does not establish specific limitations on services classified to the emergency medical services category that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified to this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization." For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations;

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

(i) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

(ii) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(iii) The following types of surgery:

(A) Bariatric surgery and supplies;

(B) Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly; and

(C) Sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

(v) Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan allows for a transplant waiting period. This waiting period is not part of the state EHB-benchmark plan.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. This benefit may be classified to this category for determining actuarial value or to the rehabilitation services category, but not to both.

(e) State benefit requirements classified to this category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530);

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn" services. For purposes of determining a plan's actuarial value, an issuer must classify as maternity and newborn services the medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery, and to newborn children, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy. Termination of pregnancy may be included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115.

(b) A health benefit plan may, but is not required to, include the following service as part of the EHB-benchmark package. Genetic testing of the child's father is specifically excluded by the base-benchmark plan, and should not be included in determining actuarial value.

(c) The base-benchmark plan establishes specific limitations on services classified to the maternity and newborn category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Maternity coverage for dependent daughters must be included in the EHB-benchmark plan on the same basis that the coverage is included for other enrollees;

(ii) Newborns delivered of dependent daughters must be covered to the same extent, and on the same basis, as newborns delivered to the other enrollees under the plan.

(d) The base-benchmark plan's limitations on services in this category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(e) State benefit requirements classified to this category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the post-natal coverage for the mother, for no less than three weeks (RCW 48.43.115);

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment." For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, the medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential and outpatient mental health and substance use disorder treatment, including partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.

(b) A health benefit plan may, but is not required to include, the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the DSM-IV, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger, unless this exclusion is preempted by federal law;

(iii) Not medically necessary court-ordered mental health treatment.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Coverage for eating disorder treatment must be covered when associated with a diagnosis of a DSM categorized mental health condition;

(ii) Chemical detoxification coverage must not be uniformly limited to thirty days. Medical necessity, utilization review and criteria consistent with federal law may be applied by an issuer in designing coverage for this benefit;

(iii) Mental health services and substance use disorder treatment must be delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include: Court ordered treatment only when medically necessary.

(e) State benefit requirements classified to this category include:

(i) Mental health services (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355);

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.292).

(f) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec.

300gg-26) where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services." For purposes of determining a plan's actuarial value, an issuer must classify as prescription drug services the medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan and classify them as prescription drug services:

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (f) of this subsection;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA approved contraceptive methods, and prescription based sterilization procedures for women with reproductive capacity;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order;

(v) Medical foods to treat inborn errors of metabolism.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and

(ii) Weight loss drugs.

(c) The base-benchmark plan establishes specific limitations on services classified to the prescription drug services category that conflict with state or federal law as of January 1, 2014. The EHB-benchmark plan requirements for these services are:

(i) Preauthorized tobacco cessation products must be covered consistent with state and federal law;

(ii) Medication prescribed as part of a clinical trial, which is not the subject of the trial, must be covered in a manner consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its health benefit plan;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(e) State benefit requirements classified to this category include:

(i) Medical foods to treat phenylketonuria (RCW 48.44.440, 48.46.510, 48.20.520, and 48.21.300);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit re-

quirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(f) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.

(i) An issuer must file its formulary quarterly, following the filing instructions defined by the insurance commissioner in WAC 284-44A-040, 284-46A-050, and 284-58-025.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "rehabilitative and habilitative services."

(a) For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled, in a manner substantially equal to the base-benchmark plan.

(b) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) In-patient rehabilitation facility and professional services delivered in those facilities;

(iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

(i) Off the shelf shoe inserts and orthopedic shoes;

(ii) Exercise equipment for medically necessary conditions;

(iii) Durable medical equipment that serves solely as a comfort or convenience item; and

(iv) Hearing aids other than cochlear implants.

(d) **Supplementation:** The base-benchmark plan does not cover certain federally required services under this category. A health benefit plan must cover habilitative services, but these services are not specifically covered in the base-benchmark plan. Therefore, this category is supplemented. The state EHB-benchmark plan requirements for habilitative services are:

(i) For purposes of determining actuarial value and complying with the requirements of this section, the issuer must classify as ha-

bilitative services and provide coverage for the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping or learning age appropriate skills and functioning within the individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness.

(ii) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include reference based limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.

(iii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all of the services in a plan of treatment are provided by a public or government program.

(iv) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.

(v) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(vi) Consistent with the standards in this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(vii) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in this category include:

(i) In-patient rehabilitation facility and professional services delivered in those facilities are limited to thirty service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(f) State benefit requirements classified to this category include:

(i) State sales tax for durable medical equipment; and

(ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(g) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent

with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services." For purposes of determining actuarial value, an issuer must classify as laboratory services the medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X ray, MRI, CAT scan and PET scans, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging;

(iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. An enrollee's not medically indicated procurement and storage of personal blood supplies provided by a member of the enrollee's family is specifically excluded by the base-benchmark plan, and should not be included by an issuer in establishing a health benefit plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management." For purposes of determining a plan's actuarial value, an issuer must classify as preventative and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic, services that assist in the multidisciplinary management and treatment of chronic diseases, services of particular preventive or early identification of disease or illness of value to specific populations, such as women, children and seniors, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services as preventive and wellness services:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii) Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force for prevention and chronic care, for recommendations issued on or before the applicable plan year;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians;

(iv) Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines;

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication

management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vi) Wellness services.

(b) The base-benchmark plan does not exclude any services that could reasonably be classified to this category.

(c) The base-benchmark plan does not apply any limitations or scope restrictions that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275);

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

(10) State benefit requirements that are limited to those receiving pediatric services, but that are classified to other categories for purposes of determining actuarial value, are:

(a) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories;

(b) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.250). This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.

(11) This section expires on December 31, 2016.

NEW SECTION

WAC 284-43-8781 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "ambulatory patient services" those medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and outpatient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiology, professional surgical services, surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the ambulatory category:

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth. However, health plans must cover oral surgery related to trauma and injury. Therefore, a plan may not exclude services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease;

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Nonskilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them. However, plans must cover cochlear implants and hearing screening tests that are required under the preventive services category, unless coverage for these services and devices are required as part of and classified to another essential health benefits category; and

(viii) Obesity or weight reduction or control other than covered nutritional counseling.

(c) The base-benchmark plan's visit limitations on services in the ambulatory patient services category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime; and

(iv) One hundred thirty visits per calendar year for home health care.

(d) State benefit requirements classified to the ambulatory patient services category are:

(i) Chiropractic care (RCW 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530); and

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as emergency medical services the care and services related to an emergency medical condition.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room and department based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not specifically exclude services classified to the emergency medical services category.

(c) The base-benchmark plan does not establish visit limitations on services in the emergency medical services category.

(d) State benefit requirements classified to the emergency medical services category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations; and

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the hospitalization category:

(i) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

(ii) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(iii) The following types of surgery:

(A) Bariatric surgery and supplies;

(B) Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly.

(iv) Reversal of sterilizations; and

(v) Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans:

(i) The base-benchmark plan allows a waiting period for transplant services; and

(ii) The base-benchmark plan excludes coverage for sexual reassignment treatment, surgery, or counseling services. Health plans must cover such services consistent with 42 U.S.C. 18116, Section 1557, RCW 48.30.300 and 49.60.040.

(d) The base-benchmark plan's visit limitations on services in the hospitalization category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. For purposes of determining actuarial value, this benefit may be classified to the hospitalization category or to the rehabilitation services category, but not to both.

(e) State benefit requirements classified to the hospitalization category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530); and

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as maternity and newborn services the medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery and to newborn children.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy. Termination of pregnancy may be included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115.

(b) A health benefit plan may, but is not required to, include genetic testing of the child's father as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer covers this benefit, the issuer may not include this benefit in establishing actuarial value for the maternity and newborn category.

(c) The base-benchmark plan's limitations on services in the maternity and newborn services category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(d) State benefit requirements classified to the maternity and newborn services category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the postnatal coverage for the mother, for no less than three weeks (RCW 48.43.115); and

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, the medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential, and outpatient mental health and substance use disorder treatment, including diagnosis, partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication including medications prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-

benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the category of mental health and substance use disorder services including behavioral health treatment:

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria consistent with 42 U.S.C. 18116, Section 1557, RCW 48.30.300 and 49.60.040, unless this exclusion is preempted by federal law; and

(iii) Court-ordered mental health treatment which is not medically necessary.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2017. The state EHB-benchmark plan requirements for these services are: The base-benchmark plan does not provide coverage for mental health services and substance use disorder treatment delivered in a home health setting in parity with medical surgical benefits consistent with state and federal law. Health plans must cover mental health services and substance use disorder treatment that is delivered in parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include court-ordered treatment only when medically necessary.

(e) State benefit requirements classified to this category include:

(i) Mental health services (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355); and

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.292).

(f) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) including where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as prescription drug services medically necessary prescribed drugs, medication and drug therapies.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as prescription drug services:

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (e) of this subsection;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA-approved contraceptive methods, and prescription-based sterilization procedures for women with reproductive capacity;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order; and

(v) Medical foods to treat inborn errors of metabolism in accordance with RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services for the prescription drug services category. If an issuer includes these services, the issuer may not include the following benefits in establishing actuarial value for the prescription drug services category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and

(ii) Weight loss drugs.

(c) The base-benchmark plan's visit limitations on services in the prescription drug services category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its health benefit plan;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(d) State benefit requirements classified to the prescription drug services category include:

(i) Medical foods to treat inborn errors of metabolism (RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241);

(e) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark plan formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.

(i) An issuer must file its formulary quarterly, following the filing instructions defined by the insurance commissioner in WAC 284-44A-040, 284-46A-050, and 284-58-025.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "rehabilitative and habilitative services" in a manner substantially equal to the base-benchmark plan.

(a) For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled.

(b) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) Inpatient rehabilitation facilities and professional services delivered in those facilities;

(iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatus used to support, align or correct deformities or to improve the function of moving parts; and

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the rehabilitative and habilitative services category:

(i) Off-the-shelf shoe inserts and orthopedic shoes;

(ii) Exercise equipment for medically necessary conditions;

(iii) Durable medical equipment that serves solely as a comfort or convenience item; and

(iv) Hearing aids other than cochlear implants.

(d) For purposes of determining a plan's actuarial value, an issuer must classify as habilitative services the range of medically necessary health care services and health care devices designed to assist a person to keep, learn or improve skills and functioning for daily living. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient or outpatient settings.

(i) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include such limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity re-

quirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.

(ii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all, of the services in a plan of treatment are provided by a public or government program.

(iii) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.

(iv) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(v) Consistent with the standards in this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(vi) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in the rehabilitative and habilitative services category include:

(i) Inpatient rehabilitation facilities and professional services delivered in those facilities are limited to thirty service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(f) State benefit requirements classified to this category include:

(i) State sales tax for durable medical equipment; and

(ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(g) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services" in a manner substantially equal to the base-benchmark plan. For purposes of determining actuarial value, an issuer must classify as laboratory services the medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X ray, MRI, CAT scan and PET scans.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging; and

(iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes procurement and storage of personal blood supplies provided by a member of the enrollee's family when this service is not medically indicated. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing the health plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic; services that assist in the multidisciplinary management and treatment of chronic diseases; and services of particular preventative or early identification of disease or illness of value to specific populations, such as women, children and seniors.

(a) If a plan does not have in its network a provider who can perform the particular service, then the plan must cover the item or service when performed by an out-of-network provider and must not impose cost-sharing with respect to the item or service. In addition, a health plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. If a provider determines that a sex-specific recommended preventive service is medically appropriate for an individual, and the individual otherwise satisfies the coverage requirements, the plan must provide coverage without cost-sharing.

(b) A health benefit plan must include the following services as preventive and wellness services, including chronic disease management:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii)(A) Screening and tests for which the U.S. Preventive Services Task Force for Prevention and Chronic Care have issued A and B recommendations on or before the applicable plan year.

(B) To the extent not specified in a recommendation or guideline, a plan may rely on the relevant evidence base and reasonable medical management techniques, based on necessity or appropriateness, to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration ("HRSA") Bright Futures guidelines as set forth by the American Academy of Pediatricians; and

(iv) Services, tests, screening and supplies recommended in the HRSA women's preventive and wellness services guidelines:

(A) If the plan covers children under the age of nineteen, or covers dependent children age nineteen or over who are on the plan

pursuant to RCW 48.44.200, 48.44.210, or 48.46.320, the plan must provide the child with the full range of recommended preventive services suggested under HRSA guidelines for the child's age group without cost-sharing. Services provided in this regard may be combined in one visit as medically appropriate or may be spread over more than one visit, without incurring cost-sharing, as medically appropriate; and

(B) A plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive service, including providing multiple prevention and screening services at a single visit or across multiple visits.

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vi) Wellness services.

(c) The base-benchmark plan does not specifically exclude any services that could reasonably be classified to this category.

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed under (b)(i) through (iv) of this subsection that are provided in-network.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275); and

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

(10) Some state benefit requirements are limited to those receiving pediatric services, but are classified to other categories for purposes of determining actuarial value.

(a) These benefits include:

(i) Neurodevelopmental therapy, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories; and

(ii) Treatment of congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.250). This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.

(b) The base-benchmark plan contains limitations or scope restrictions that conflict with state or federal law as of January 1, 2017. Specifically, the plan covers outpatient neurodevelopmental therapy services only for persons age six and under. Health plans must cover medically necessary neurodevelopmental therapy for any DSM diagnosis without blanket exclusions.

(11) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently

asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(12) This section applies to health plans that have an effective date of January 1, 2017, or later.

AMENDATORY SECTION (Amending WSR 14-09-080, filed 4/18/14, effective 5/19/14)

WAC 284-43-879 Essential health benefit category—Pediatric oral services. A health benefit plan must include "pediatric dental benefits" in its essential health benefits package. Pediatric dental benefits means coverage for the oral services listed in subsection (3) of this section, delivered to those under age nineteen.

(1) For benefit years beginning January 1, 2015, a health benefit plan must include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. For a health benefit plan certified by the health benefit exchange as a qualified health plan, this requirement is met if a stand-alone dental plan meeting the requirements of subsection (3) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-878 and 284-43-880 are not applicable to the stand-alone dental plan. A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(3) **Supplementation:** The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878, but does not cover pediatric oral services. Because the base-benchmark plan does not cover pediatric oral benefits, the state EHB-benchmark plan requirements are supplemented for pediatric oral benefits. The Washington state CHIP plan is designated as the supplemental base-benchmark plan for pediatric dental benefits. A health plan issuer must offer coverage for and classify the following pediatric oral services as pediatric dental benefits in a manner substantially equal to the supplemental base-benchmark plan:

(a) Diagnostic services;

(b) Preventive care;

(c) Restorative care;

(d) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;

(e) Endodontic treatment;

(f) Periodontics;

(g) Crown and fixed bridge;

(h) Removable prosthetics; and

(i) Medically necessary orthodontia.

(4) The supplemental base-benchmark plan's visit limitations on services in this category are:

(a) Diagnostic exams once every six months, beginning before one year of age;

(b) Bitewing X ray once a year;
(c) Panoramic X rays once every three years;
(d) Prophylaxis every six months beginning at age six months;
(e) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;
(f) Every two years for the same restoration (fillings);
(g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;
(h) Root canals on baby primary posterior teeth only;
(i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;
(j) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with prior authorization;
(k) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with prior authorization;
(l) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;
(m) Stainless steel crowns for permanent posterior teeth once every three years;
(n) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;
(o) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;
(p) One resin based partial denture, if provided at least three years after the seat date;
(q) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;
(r) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seat date.

(5) This section expires on December 31, 2016.

NEW SECTION

WAC 284-43-8791 Essential health benefit category—Pediatric oral services. A health benefit plan must include "pediatric dental benefits" in its essential health benefits package. Pediatric dental benefits means coverage for the oral services listed in subsection (3) of this section, delivered to those under age nineteen. Plans must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age nineteen.

(1) For benefit years beginning January 1, 2017, a health benefit plan must include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. For a health benefit plan certified by the health benefit exchange as a qualified health plan, this requirement is met if a stand-alone dental plan meeting the requirements of sub-

section (4) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-8781 and 284-43-8801 are not applicable to the stand-alone dental plan.

(3) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(4) The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-8781 and covers pediatric oral services. The designated base-benchmark plan for pediatric dental benefits consists of the benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* small group plan policy form, policy form number WW0114CCONMSD, and certificate form number WW0114BPPO1SD, offered during the first quarter of 2014 (SERFF filing number RGWA-128968362). A health plan issuer must offer coverage for and classify the following pediatric oral services as pediatric dental benefits in a manner substantially equal to the base-benchmark plan:

(a) Diagnostic services;

(b) Preventive care;

(c) Restorative care;

(d) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;

(e) Endodontic treatment, not including indirect pulp capping;

(f) Periodontics;

(g) Crown and fixed bridge;

(h) Removable prosthetics; and

(i) Medically necessary orthodontia.

(5) The base-benchmark plan's visit limitations on services in this category are:

(a) Diagnostic exams once every six months, beginning before one year of age, plus limited oral evaluations when necessary to evaluate for a specific dental problem or oral health complaint, dental emergency or referral for other treatment;

(b) Limited visual oral assessments or screenings, limited to two per member per calendar year, not performed in conjunction with other clinical oral evaluation services;

(c) Two sets of bitewing X rays once a year for a total of four bitewing X rays per year;

(d) Cephalometric films, limited to once in a two-year period;

(e) Panoramic X rays once every three years;

(f) Occlusal intraoral X rays, limited to once in a two-year period;

(g) Periapical X rays not included in a complete series for diagnosis in conjunction with definitive treatment;

(h) Prophylaxis every six months beginning at age six months;

(i) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; and three times in a twelve-month period during orthodontic treatment;

(j) Sealant once every three years for permanent bicuspids and molars only;

(k) Oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;

(l) Restorations (fillings) on the same tooth every two years;

(m) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;

(n) Root canals on baby primary posterior teeth only;

(o) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17, and 32;

(p) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older;

(q) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older;

(r) Stainless steel crowns for primary anterior teeth once every three years, if age thirteen and older;

(s) Stainless steel crowns for permanent posterior teeth once every three years;

(t) Installation of space maintainers (fixed unilateral or fixed bilateral) for members twelve years of age or under, including:

(i) Recementation of space maintainers;

(ii) Removal of space maintainers; and

(iii) Replacement space maintainers when dentally appropriate.

(u) One resin-based partial denture, if provided at least three years after the seat date;

(v) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;

(w) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seat date.

(6) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(7) This section applies to health plans that have an effective date of January 1, 2017, or later.

AMENDATORY SECTION (Amending WSR 14-23-092, filed 11/19/14, effective 12/20/14)

WAC 284-43-880 Pediatric vision services. A health benefit plan must include "pediatric vision services" in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878 (1) through (9), but does not include pediatric vision services. Pediatric vision services are vision services delivered to enrollees under age nineteen.

(1) A health benefit plan must cover pediatric vision services as an embedded set of services.

(2) **Supplementation:** The state EHB-benchmark plan requirements for pediatric vision benefits must be offered at a substantially equal level and classified consistent with the designated supplemental base-benchmark plan for pediatric vision services, the Federal Employees Vision Plan with the largest enrollment and published by the U.S. Department of Health and Human Services at www.cciioo.cms.gov on July 2, 2012.

(a) The vision services included in the pediatric vision services category are:

(i) Routine vision screening; and

(ii) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;

(iii) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular lenses;

(iv) One pair of frames every calendar year. An issuer may establish networks or tiers of frames within their plan design as long as there is a base set of frames to choose from available without cost sharing;

(v) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. Issuers must apply this limitation based on the manner in which the lenses must be dispensed. If disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. The benefit includes the evaluation, fitting and follow-up care relating to contact lenses. If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism;

(vi) Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:

(A) One comprehensive low vision evaluation every five years;

(B) High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and

(C) Follow-up care of four visits in any five year period, with prior approval.

(b) The pediatric vision supplemental base-benchmark specifically excludes, and issuer must not include in its actuarial value for the category:

(i) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan;

(ii) Two pairs of glasses may not be ordered in lieu of bifocals;

(iii) Medical treatment of eye disease or injury, which is otherwise covered under the medical/surgical benefits of the plan;

(iv) Nonprescription (Plano) lenses; and

(v) Prosthetic devices and services, which are otherwise covered under the rehabilitative and habilitative benefit category.

(3) This section expires on December 31, 2016.

NEW SECTION

WAC 284-43-8801 Pediatric vision services. A health benefit plan must include "pediatric vision services" in its essential health benefits package. The designated base-benchmark plan for pediatric vision benefits consists of the benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* small group plan policy form, policy form number WW0114CCONMSD, and

certificate form number WW0114BPPO1SD, offered during the first quarter of 2014 (SERFF filing number RGWA-128968362).

(1) A health benefit plan must cover pediatric vision services as an embedded set of services.

(2) For the purpose of determining a plan's actuarial value, an issuer must classify as pediatric vision services the following vision services delivered to enrollees until at least the end of the month in which enrollees turn age nineteen:

(a) Routine vision screening;

(b) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;

(c) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular lenses;

(d) One pair of frames every calendar year. An issuer may establish networks or tiers of frames within their plan design as long as there is a base set of frames to choose from available without cost-sharing;

(e) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. Issuers must apply this limitation based on the manner in which the lenses must be dispensed. If disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. The benefit includes the evaluation, fitting and follow-up care relating to contact lenses. If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism;

(f) Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:

(i) One comprehensive low vision evaluation every five years;

(ii) High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and

(iii) Follow-up care of four visits in any five-year period, with prior approval.

(3) The base-benchmark plan specifically excludes the following benefits. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing the plan's actuarial value for the pediatric vision services category:

(a) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan; and

(b) Ordering two pairs of glasses in lieu of bifocals.

(4) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(5) This section applies to health plans that have an effective date of January 1, 2017, or later.