Exhibit B: Washington EHBs on the 2022 Plans & Benefits Template

Purpose

These instructions explain how to correctly populate the Essential Health Benefit (EHB) information of your Plans and Benefits template (PBT) for Washington State. Note that the changes included in these instructions are in addition to the changes made by the Washington State EHB add-In file provided by the Center for Consumer Information and Insurance Oversight (CCIIO).

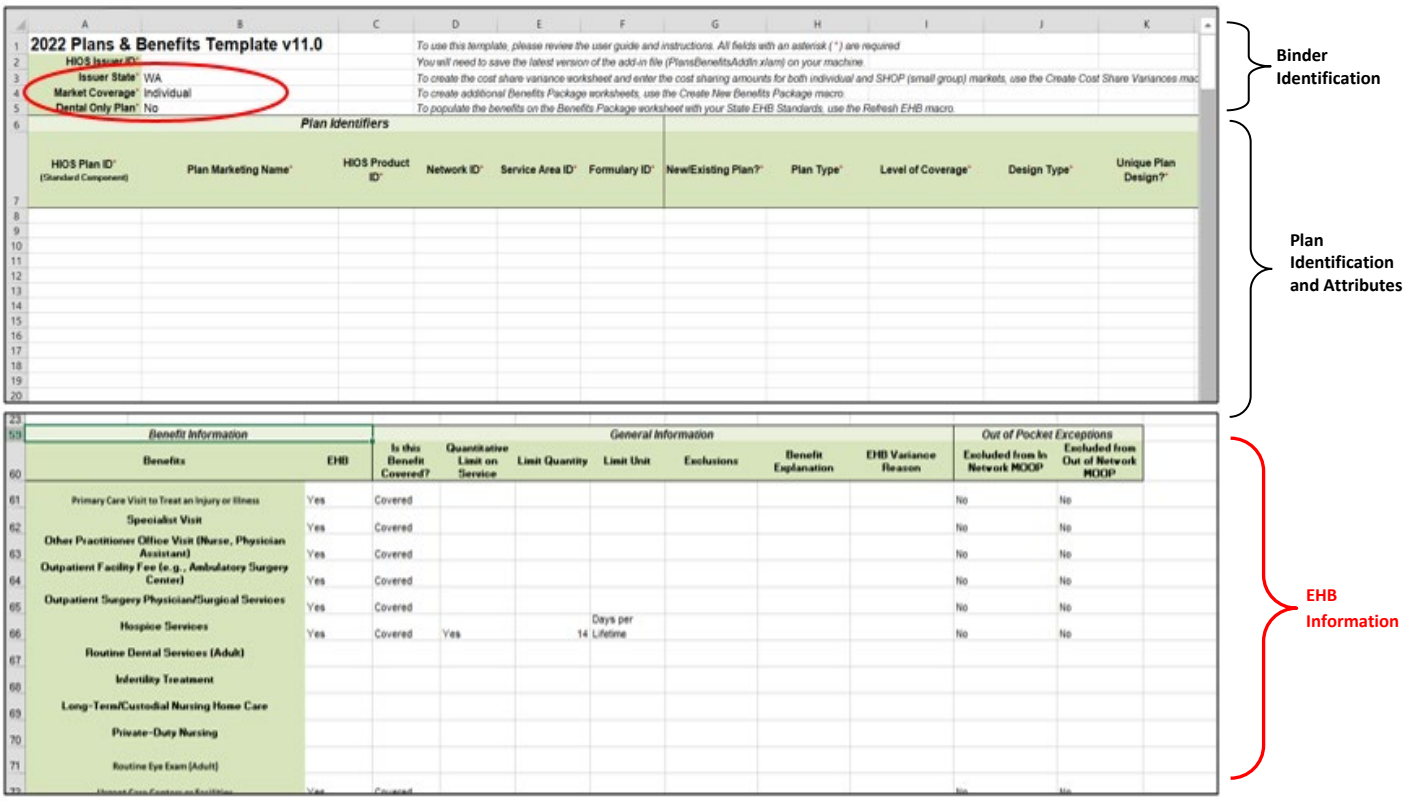
Please go to the CCIIO Qualified Health Plan Application Instructions, Templates and Materials page (https://www.qhpcertification.cms.gov/s/Application%20Materials) for 2022 Qualified Health Plan templates and Add-In files.

Summary of Changes Plan Year 2022

There are no changes from the 2021 to the 2022 Add-in file for Washington State. These instructions are essentially the same as Plan Year 2021.

Background Information

The Plans & Benefits template (PBT) is an Excel workbook made up of at least two worksheets. One is labeled "Benefits Package [Number]", and the other is labeled "Cost Share Variances [Number]". The Benefits Package worksheet is separated into three sections. The first section is the identification of the issuer and market to which the binder applies (labeled "Binder Identification" in the screen shot below). The next section is where the issuer identifies the plans and their attributes (labeled "Plan Identification and Attributes" in the screen shot below). These sections are followed by the third section that begins with the heading "Benefit Information" across columns A through C. (Labeled "EHB Information" in the screen shot below.) This third section includes the information about coverage of the Essential Health Benefits ("EHBs") required in the applicable state.



CCIIO provides an add-in file that helps users complete the EHB Information section of the PBT. The add-in file will populate the EHB Information automatically once the "Issuer State" (WA) and applicable "Market Coverage" or "Dental Only Plan" fields are selected in the "Binder Identification" portion of the template (red circle). Although most of this information is correct, some changes are required. These instructions explain how to make changes necessary to correct the information that is automatically populated, and to customize it based on your plan design.

How to use these instructions

There are two sections to these instructions: these narrative instructions and a visual map of corrections (referred to in the General Filing Instructions as *Exhibit C, Visual Map of PBT with Washington EHBs*). The two sections are designed to be used in combination.

Exhibit C - Visual map

The visual map is an Excel workbook with 3 sheets. The sheet labeled "Individual Medical" shows the changes to be made in medical individual market PBTs. The sheet labeled "Small Group Medical" shows the changes to be made in medical small group market PBTs. The sheet labeled "SAPDental" shows the changes to be made in stand-alone pediatric dental PBTs for both the individual and small group markets. Each sheet contains two views: how the EHB

information is populated by the PBT add-in file, and how the final EHB information must look in each Benefits Package worksheet of the PBT when submitted to the OIC. Note that the visual map includes some changes that will be made depending on the benefits covered in the specific plan shown on the PBT. See the legend below.

The visual map for medical plans is designed so that sheets 1 and 2 can be printed double-sided, making a one-page (Legal Paper Size) reference for your use. Sheet 3 can be printed as a separate sheet for use with SAPD plans.

Legend

Red: Required Changes

Gold: Optional Changes (whether a change is necessary depends on whether and how the benefit is covered)

Medical Plans Instructions

Columns: You will be working in the following columns in the PBT:

Column Letter	Column Heading
D	Is this Benefit Covered?
E	Quantitative Limit on Service
F	Limit Quantity
G	Limit Unit
I	Benefit Explanation
J	EHB Variance Reason

All Generic and Brand Drugs (whether preferred or non-preferred):

The Washington State EHB add-in file includes the following in the Benefit Explanation column (Column I): "Coverage is limited to a 30-day supply retail or 90-day supply mail order."

- If your product contains **the same quantitative limits** on prescription fills and refills as the base benchmark plan (30 day supply when purchased at a participating pharmacy or a 90-day supply when purchased via mail order), you must:
    - Add the words "per fill or refill" to the end of the benefit explanation in Column I for Generic and Preferred Brand Drugs, and add the entire explanation "Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.") to Column I for Non-Preferred Brand Drugs; and

  - Populate column E with "Yes".
- If your product limits prescription fills and refills, but contains **less restrictive limits** than the base benchmark plan, you must:
  - Change the benefit explanation in Column I to accurately reflect the product's benefit; and
  - Populate column E with "Yes".
  - Populate column F with "30".
  - Populate column G with "Days per Month".
  - Populate column J with "Other Law/Regulation".

- If your product **does not limit** the quantity of prescription fills and refills, you must delete the benefit explanation in Column I for Generic and Preferred Brand Drugs.

Specialty Drugs

The State EHB add-in file includes the following in the Benefit Explanation column (Column I): "First fill allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy. Coverage is limited to a 30-day supply for specialty and self-administrable cancer chemotherapy medications from a specialty pharmacy."

- If your product contains **the same quantitative limits** on specialty drug fills and refills as the base benchmark plan, you must:
  - Add the words "per fill or refill" to benefit explanation in Column I, so that the explanation reads, "First fill allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy. Coverage is limited to a 30-day supply per fill or refill for specialty and self-administrable cancer chemotherapy medications from a specialty pharmacy"; and
  - Populate column E with "Yes".
- If your product limits specialty drug fills and refills, but contains **less restrictive limits** than the base benchmark plan, you must:
  - Change the benefit explanation in Column I to accurately reflect the product's benefit; and
  - Populate column E with "Yes".
  - Populate column F with "30".
  - Populate column G with "Days per Month".
  - Populate column J with "Other Law/Regulation".

- If your product **does not limit** the quantity of specialty drug fills and refills, you must delete the benefit explanation in Column I.

Habilitation Services

The State EHB add-in file populates the "Habilitation Services" row, Column F ("Limit Quantity") with a visit limit of 25 visits per year. The EHB requirement is coverage of 30 inpatient days/year and 25 outpatient visits/year. Since that field will accept only whole numbers, it must reflect either 25 or 30. Therefore, the State EHB add-in correctly populates this field with 25.

However, the same issue occurs in the rows labeled "rehabilitative speech therapy" and "rehabilitative occupational and rehabilitative physical therapy". In those rows, however, the State EHB add-in populates Column F ("limit quantity") with the requirement for inpatient days, which is 30. For the reasons above, this number is also correct. But it is a *different* number in the same situation. For purposes of consistency and clarity, therefore:

- You must populate Column F of the "Habilitative Services" row with "30".
- You must populate Column J of the "Habilitative Services" row with "Other Law/Regulation".

Reconstructive Surgery

Reconstructive breast surgery and reconstructive surgery for the treatment of congenital anomalies is required under Washington law. RCW 48.20.395, 48.20.430, 48.21.155, 48.21.230, 48.44.212, 48.44.330, 48.46.250, 48.46.280, WAC 284-43-5642(3)(b)(ii), and WAC 284-50-320(6)(e). Because a WAC citation in the State EHB add-in file requires correction, and because coverage of reconstructive surgery is only required (and therefore an EHB which can be included in AV calculation) in the above situations:

- You must delete the pre-populated information in Column I and populate Column I with the following: "Coverage for reconstructive breast surgery and treatment of congenital anomalies is required and is covered under the state base benchmark plan."

Abortion for Which Public Funding is Prohibited

- If your product does **not** cover abortion for which public funding is prohibited, no changes are required in this row. The State EHB add-in file accurately reflects a product that does not include coverage for abortion for which public funding is prohibited.

If your product **does** cover abortion for which public funding is prohibited, you must populate Column D with "Covered", and populate Column J with "Additional EHB Benefit".

Dental Anesthesia

- You first must add Dental Anesthesia to the Benefits Information using the "Add Benefit" button provided in the PBT add-in file.

- Then you must populate Column D with "Covered" and populate Column J with "Additional EHB Benefit".

Diabetes Care Management

- You first must add Diabetes Care Management to the Benefits Information using the "Add Benefit" button provided in the PBT add-in file.
- Then you must populate Column D with "Covered" and populate Column J with "Additional EHB Benefit".

Inherited Metabolic Disorder – PKU

- You first must add Inherited Metabolic Disorder - PKU to the Benefits Information using the "Add Benefit" button provided in the PBT add-in file.
- Then you must populate Column D with "Covered" and populate Column J with "Additional EHB Benefit".

Dental Check-Up for Children:

- If your product **DOES** have embedded pediatric dental benefits, no changes are required in this row. The State EHB add-in file accurately reflects a product that includes coverage for the pediatric EHB requirement of 2 dental check-ups per year.
    - NOTE: you may cover more than 2 pediatric dental check-ups. The number in Column G must reflect the actual number of covered pediatric dental check-ups.
- If your product does **NOT** have embedded pediatric dental benefits, you must populate Column E with "Not Covered", clear the contents of Columns E through G, and populate Column J with "Dental Only Plan Available".

Basic Dental Care – Child:

- If your product **DOES** have embedded pediatric dental benefits, and the product limits the number of pediatric basic dental care visits to one per year, no changes are required in this row. The State EHB add-in file accurately reflects a product that includes coverage for this pediatric EHB requirement.
    - Note: The EHB requires coverage of at least one pediatric basic dental care visit, but you may cover as many such visits as desired. The number in Column F must reflect the actual number of covered pediatric basic dental care visits.
- If your product does **NOT** have embedded pediatric dental benefits, you must populate Column D with "Not Covered", clear the contents of columns E through G, and populate Column J with "Dental Only Plan Available".

Orthodontia – Child:

- If your product **DOES** have embedded pediatric dental benefits, no changes are required in this row. The State EHB add-in file accurately reflects a product that includes coverage for medically necessary pediatric orthodontia.
- If your product does **NOT** have embedded pediatric dental benefits, you must populate Column D with "Not Covered", and populate Column J with "Dental Only Plan Available".

Major Dental Care – Child:

- If your product has embedded pediatric dental benefits, no changes are required in this row. The State EHB add-in file accurately reflects a product that includes coverage for the pediatric EHB for major dental care (once every 2 years for the same restoration).
    - NOTE: you may cover more pediatric major dental care than the EHB minimum. Your PBT must reflect the actual covered pediatric major dental care benefits.
- If your product does **NOT** have embedded pediatric dental benefits, you must populate Column D with "Not Covered", clear the contents of Column I, and populate Column J with "Dental Only Plan Available".

Adult Dental Benefit Instructions

Basic Dental Care – Adult:

Orthodontia – Adult:

Major Dental Care – Adult:

Accidental Dental:

- If your product does **NOT** have adult dental benefits, no changes are required in these rows. The State EHB add-in file accurately reflects a product that does not include adult dental benefits.
- If your product **DOES** have adult dental benefits, you must:
    - Populate Columns D through I to accurately reflect the benefits offered; and
    - Populate Column J with "Not EHB".

Other Optional Changes

Acceptable optional changes indicated in this document are not all inclusive. The issuer must make additional changes to the Benefit Packages worksheet that are required to accurately reflect the actual benefits covered in the corresponding form; however, benefits must not be

more restrictive than the benchmark plan. For example, the benefit limitation for Generic Drugs is "Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill" per the benchmark plan; however, this limitation can change to be less restrictive; for example, "Coverage is limited to a 90-day supply retail or 90-day supply mail order per fill or refill."

IMPORTANT: EHB Variance Reasons (Column J) "Substituted," "Substantially Equal," and "Using Alternate Benchmark" <u>are not acceptable</u> variance reasons in Washington State.