

**WSR 26-01-148  
PERMANENT RULES  
OFFICE OF THE  
INSURANCE COMMISSIONER**

[Insurance Commissioner Matter R 2025-12—Filed December 19, 2025, 7:35 a.m., effective January 19, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This rule is necessary to update existing rules to align with changes in state and federal law and insurance-related legislation. The rule ensures that affected entities understand their rights and obligations under the new legislation. The rule updates the essential health benefit plan coverage requirements. The rule also provides greater clarity around reporting responsibilities for ground ambulance locally set rates.

The rule updates include chapter 284-43 WAC, Subchapter D, Prior authorization and utilization review; chapter 284-43 WAC, Subchapter H, Health plan benefits; chapter 284-43 WAC, Subchapter L, Reproductive health care and contraception; and WAC 284-43-7010 and 284-43B-029.

Citation of Rules Affected by this Order: New WAC 284-43-2070, 284-43-5604, 284-43-5624, 284-43-5644, 284-43-5704, 284-43-5784, and 284-43-5939; repealing WAC 284-43-5600, 284-43-5620, 284-43-5640, 284-43-5700, and 284-43-5780; and amending WAC 284-43-2050, 284-43-5151, 284-43-5410, 284-43-5602, 284-43-5622, 284-43-5642, 284-43-5702, 284-43-5782, 284-43-5937, 284-43-7010, 284-43-7210, and 284-43B-029.

Statutory Authority for Adoption: RCW 48.02.060 and 48.49.110.

Other Authority: Chapter 366, Laws of 2024; chapter 25, Laws of 2025; and chapter 171, Laws of 2025.

Adopted under notice filed as WSR 25-22-100 on November 5, 2025.

A final cost-benefit analysis is available by contacting Rules Coordinator, P.O. Box 40260, Olympia, WA 98504, phone 360-725-7000, email rulescoordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 7, Amended 9, Repealed 5.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: December 19, 2025.

Patty Kuderer  
Insurance Commissioner

**RDS-6760.2**

AMENDATORY SECTION (Amending WSR 25-02-084, filed 12/27/24, effective 1/27/25)

**WAC 284-43-2050 Prior authorization processes.** (1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018. Unless stated otherwise, this section does not apply to prescription drug services. For health plans as defined in RCW 48.43.005, carriers must meet the requirements of RCW 48.43.830 in addition to the requirements in this section.

(2) A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use evidence-based clinical review criteria. A carrier or its designated or contracted representative must make determinations in accordance with the carrier's current clinical review criteria and use the medical necessity definition stated in the enrollee's plan. The prior authorization program must include a method for reviewing and updating clinical review criteria. A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. A carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program. A carrier or its designated or contracted representative is not required to use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.

(3) A prior authorization program must meet standards set forth by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and Accreditation Association for Ambulatory Health Care in addition to the requirements of this chapter. A prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.

(4) Effective November 1, 2019, a carrier or its designated or contracted representative must have a current and accurate online prior authorization process. All parts of the process that utilize personally identifiable information must be accessed through a secure online process. The online process must be accessible to a participating provider and facility so that, prior to delivering a service, a provider and facility will have enough information to determine if a service is a benefit under the enrollee's plan and the information necessary to submit a complete prior authorization request. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system. The online process must provide the information required for a provider or facility to determine for an enrollee's plan for a specific service:

- (a) If a service is a benefit;
  - (b) If a prior authorization request is necessary;
  - (c) What, if any preservice requirements apply; and
  - (d) If a prior authorization request is necessary, the following information:
    - (i) The clinical review criteria used to evaluate the request;
- and
- (ii) Any required documentation.

(5) Effective November 1, 2019, in addition to other methods to process prior authorization requests, a carrier or its designated or contracted representative that requires prior authorization for services must have a secure online process for a participating provider or facility to complete a prior authorization request and upload documentation if necessary. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system.

(6) Except for an integrated delivery system, a carrier or its designated or contracted representative must have a method that allows an out-of-network provider or facility to:

(a) Have access to any preservice requirements; and

(b) Request a prior authorization if prior authorization is required for an out-of-network provider or facility.

(7) A carrier or its designated or contracted representative that requires prior authorization for any service must allow a provider or facility to submit a request for a prior authorization at all times, including outside normal business hours.

(8) A carrier or its designated or contracted representative is responsible for maintaining a system of documenting information and supporting evidence submitted by a provider or facility while requesting prior authorization. This information must be kept until the claim has been paid or the appeals process has been exhausted.

(a) Upon request of the provider or facility, a carrier or its designated or contracted representative must remit to the provider or facility written acknowledgment of receipt of each document submitted by a provider or facility during the processing of a prior authorization request.

(b) When information is transmitted telephonically, a carrier or its designated or contracted representative must provide written acknowledgment of the information communicated by the provider or facility.

(9) A carrier or its designated or contracted representative must have written policies and procedures to assure that prior authorization determinations for a participating provider or facility are made within the appropriate time frames.

(a) Time frames must be appropriate to the severity of the enrollee condition and the urgency of the need for treatment, as documented in the prior authorization request.

(b) If the request from the participating provider or facility is not accompanied by all necessary information, the carrier or its designated or contracted representative must inform the provider or facility what additional information is needed and the deadline for its submission as set forth in this section.

(10) For health plans as defined in RCW 48.43.005, the prior authorization time frames for health care services and prescription drugs in RCW 48.43.830 apply.

(a) For purposes of the prior authorization time frames in RCW 48.43.830 and this subsection, the following definitions apply:

(i) "Electronic prior authorization request" means a prior authorization request that is delivered through a two-way communication system that meets the requirements of a secure online prior authorization process or an interoperable electronic process or prior authorization application programming interface.

(ii) "Nonelectronic prior authorization request" means a prior authorization request other than an electronic prior authorization re-

quest including, but not limited to, requests delivered through email, a phone call, a text message, a fax, or U.S. mail.

(b) If insufficient information has been provided to the carrier to make a prior authorization determination and the carrier requests additional information from the provider or facility under RCW 48.43.830, the initial prior authorization request time frames in RCW 48.43.830 apply once the carrier has the necessary information to make a determination. Those time frames are as follows:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of receiving the necessary information needed to make the determination.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of receiving the necessary information needed to make the determination.

(iii) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of receiving the necessary information needed to make the determination.

(iv) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of receiving the necessary information needed to make the determination.

(11) For purposes of compliance with RCW 48.43.830 effective January 21, 2027, health plans must:

(a) Establish and maintain a prior authorization application programming interface that is consistent with final rules issued by the federal Centers for Medicare and Medicaid Services and published in the federal register, and that indicates that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535; and

(b) For prior authorization of prescription drugs, a health plan must utilize the fast health care interoperability resources application programming interface for prescription drugs covered under a health plan's medical benefit; and

(c) A carrier may adopt an interoperable electronic process that complies with standards developed by the National Council for Prescription Drug Programs as an alternative to use of the fast health care interoperability resources application programming interface for prior authorization of drugs covered under a health plan's prescription drug benefit.

(12) For limited health care services contracts as defined in RCW 48.44.035, stand-alone dental plans, and stand-alone vision plans, the time frames for carrier prior authorization determination and notification to a participating provider or facility are as follows:

(a) For standard prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within five calendar days.

(ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has five calen-

dar days to request additional information from the provider or facility.

(A) The carrier or its designated or contracted representative must give a provider or facility five calendar days to give the necessary information to the carrier or its designated or contracted representative.

(B) The carrier or its designated or contracted representative must then make a decision and give notification within four calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(b) For expedited prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within two calendar days.

(ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has one calendar day to request additional information from the provider or facility.

(A) The carrier or its designated or contracted representative must give a provider or facility two calendar days to give the necessary information to the carrier or its designated or contracted representative.

(B) The carrier or its designated or contracted representative must then make a decision and give notification within two calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(iii) If the time frames for the approval of an expedited prior authorization are insufficient for a provider or facility to receive approval prior to the preferred delivery of the service, the prior authorization should be considered an extenuating circumstance as defined in WAC 284-43-2060.

~~((12))~~ (13) A carrier or its designated or contracted representative when conducting prior authorization must:

(a) Accept any evidence-based information from a provider or facility that will assist in the authorization process;

(b) Collect only the information necessary to authorize the service and maintain a process for the provider or facility to submit such records;

(c) If medical records are requested, require only the section(s) of the medical record necessary in that specific case to determine medical necessity or appropriateness of the service to be delivered, to include admission or extension of stay, frequency or duration of service; and

(d) Base review determinations on the medical information in the enrollee's records and obtained by the carrier up to the time of the review determination.

~~((13))~~ (14) When a provider or facility makes a request for the prior authorization, the response from the carrier or its designated or contracted representative must state if it is approved or denied. If the request is denied, the response must give the specific reason for the denial in clear and simple language. If the reason for the denial is based on clinical review criteria, the criteria must be provided. Written notice of the decision must be communicated to the provider or facility, and the enrollee. A decision may be provided orally, but subsequent written notice must also be provided. A denial must include the department and credentials of the individual who has the

authorizing authority to approve or deny the request. A denial must also include a phone number to contact the authorizing authority and a notice regarding the enrollee's appeal rights and process.

Whenever the prior authorization relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

~~((14))~~ (15) A prior authorization approval notification for all services must inform the requesting provider or facility, and the enrollee, whether the prior authorization is for a specific provider or facility. The notification must also state if the authorized service may be delivered by an out-of-network provider or facility and if so, disclose to the enrollee the financial implications for receiving services from an out-of-network provider or facility.

Whenever the notification relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

~~((15))~~ (16) A provider or facility may appeal a prior authorization denial to the carrier or its designated or contracted representative.

~~((16))~~ (17) Prior authorization determinations shall expire no sooner than 45 days from date of approval. This requirement does not supersede RCW 48.43.039.

~~((17))~~ (18) In limited circumstances when an enrollee has to change plans due to a carrier's market withdrawal as defined in RCW 48.43.035 (4) (d) and 48.43.038 (3) (d), the subsequent carrier or its designated or contracted representative must recognize the prior authorization of the previous carrier until the new carrier's prior authorization process has been completed and its authorized treatment plan has been initiated. The subsequent carrier or its designated or contracted representative must ensure that the enrollee receives the previously authorized initial service as an in-network service. Enrollees must present proof of the prior authorization.

(a) For medical services, a carrier or its designated or contracted representative must recognize a prior authorization for at least 30 days or the expiration date of the original prior authorization, whichever is shorter.

(b) For pharmacy services, a carrier or its designated or contracted representative must recognize a prior authorization for the initial fill, or until the prior authorization process of the new carrier or its designated or contracted representative has been completed.

~~((18))~~ (19) Prior authorization for a facility-to-facility transport that requires prior authorization can be performed after the service is delivered. Authorization can only be based on information available to the carrier or its designated or contracted representative at the time of the prior authorization request.

~~((19))~~ (20) A carrier or its designated or contracted representative must have a prior authorization process that allows specialists the ability to request a prior authorization for a diagnostic or laboratory service based upon a review of medical records in advance of seeing the enrollee.

~~((20))~~ (21) A carrier or its designated or contracted representative must have a method that allows an enrollee, provider or facility to make a predetermination request when provided for by the plan.

~~((21))~~ (22) Predetermination notices must clearly disclose to the enrollee and requesting provider or facility, that the determination is not a prior authorization and does not guarantee services will

be covered. The notice must state "A predetermination notice is not a prior authorization and does not guarantee services will be covered." Predetermination notices must be delivered within five calendar days of receipt of the request. Predetermination notices will disclose to a provider or facility for an enrollee's plan:

- (a) If a service is a benefit;
- (b) If a prior authorization request is necessary;
- (c) If any preservice requirements apply;
- (d) If a prior authorization request is necessary or if a medical necessity review will be performed after the service has been delivered, the following information:

(i) The clinical review criteria used to evaluate the request; and

- (ii) Any required documentation.

(e) Whenever a predetermination notice relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

#### NEW SECTION

**WAC 284-43-2070 Forms for authorization of inpatient or residential substance use disorder treatment.** A carrier must accept the universal format for authorization and reauthorization of inpatient or residential substance use disorder treatment services developed pursuant to section 9, chapter 366, Laws of 2024. The form will be posted on the insurance commissioner's website. Any new or updated forms will be posted on the insurance commissioner's website at least 30 days prior to their effective date.

#### **RDS-6761.2**

AMENDATORY SECTION (Amending WSR 21-24-072, filed 11/30/21, effective 1/1/22)

**WAC 284-43-5151 Unfair practice relating to gender affirming treatment and services.** When a treatment or service is gender affirming treatment, as defined in RCW 48.43.0128, it is an unfair practice for any health carrier to:

(1) Deny or limit coverage, issue automatic denials of coverage, impose additional cost sharing or other limitations or restrictions on coverage, or deny or limit coverage of a claim, if gender affirming treatment is:

(a) Prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040;

(b) Medically necessary. A carrier or its designated or contracted representative must make medically necessary determinations in accordance with the carrier's current clinical review criteria based on reasonable medical evidence and use the medical necessity definition stated in the enrollee's plan; and

(c) Prescribed in accordance with accepted standards of care;

(2) Apply blanket exclusions or categorical exclusions to gender affirming treatment; or

(3) When prescribed as medically necessary, exclude facial gender affirming treatment (such as tracheal shaves), hair removal procedures, and other care (such as mastectomies, breast reductions, breast implants, or any combination of gender affirming procedures, including revisions to prior treatment) as cosmetic services.

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

**WAC 284-43-5410 Definitions.** The following definitions apply to WAC 284-43-5400 through 284-43-5820 unless the context indicates otherwise.

"Base-benchmark plan" means the small group plan with the largest enrollment, as designated in WAC (~~(284-43-5600(1) or~~) 284-43-5602(1) (~~(r)~~) until December 31, 2025, or the updated essential health benefits benchmark plan described in WAC 284-43-5604(1), prior to any supplementation or adjustments made pursuant to RCW 48.43.715.

"EHB-benchmark plan" means the set of benefits that an issuer must include in nongrandfathered plans offered in the individual or small group market in Washington state.

"Health benefit," unless defined differently pursuant to federal rules, regulations, or guidance issued pursuant to section 1302(b) of PPACA, means health care items or services for injury, disease, or a health condition, including a behavioral health condition.

"Individual plan" includes any nongrandfathered health benefit plan offered, issued, or renewed by an admitted issuer in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to or issued through an organization meeting the definition established pursuant to 29 U.S.C. 1002(5).

"Mandated benefit" or "required benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that a health plan is required to cover by either state or federal law. Required benefits do not include provider, delivery method, or health status based requirements.

"Meaningful health benefit" means a benefit that must be included in an essential health benefit category, without which the coverage for the category does not reasonably provide medically necessary services for an individual patient's condition on a nondiscriminatory basis.

"Medical necessity determination process" means the process used by a health issuer to make a coverage determination about whether a health benefit is medically necessary for an individual patient.

"PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

"Scope or limitation requirement" means a requirement applicable to a benefit that limits its duration, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility or reference-based limitation on a specific benefit.

"Small group plan" includes any nongrandfathered health benefit plan offered, issued, or renewed by an admitted issuer in the state of Washington for the small group health benefit plan market to a small group, as defined in RCW 48.43.005, and 45 C.F.R. 144.102(c), unless the certificate of coverage is issued to a small group pursuant to a master contract held by or issued through an organization meeting the definition established pursuant to 29 U.S.C. 1002(5).

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care, as referenced in RCW 43.71.065.

AMENDATORY SECTION (Amending WSR 20-03-114, filed 1/16/20, effective 2/16/20)

**WAC 284-43-5602 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 defined in RCW 48.43.005 as "essential health benefits" 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.

(5) This section expires on December 31, 2025.

NEW SECTION

**WAC 284-43-5604 Essential health benefits package benchmark plan.** A nongrandfathered individual or small group health benefit plan offered, issued, amended, or renewed on or after January 1, 2026,

must, at a minimum, include coverage for essential health benefits.

"Essential health benefits" means all of the following:

(1) The benefits and services covered within Appendix B - Washington Essential Health Benefits Benchmark Plan and Appendix C - State EHB Benefits Benchmark Summary of Benefits as approved by the department of health and human services Centers for Medicare and Medicaid Services on October 7, 2024, as posted on the website of the office of the insurance commissioner.

(2) The services and items covered by a health benefit plan that are within the categories defined in RCW 48.43.005 as "essential health benefits" 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.

AMENDATORY SECTION (Amending WSR 20-03-114, filed 1/16/20, effective 2/16/20)

**WAC 284-43-5622 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 284-43-5642, 284-43-5702, and 284-43-5782.

(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 284-43-5642, 284-43-5702, and 284-43-5782 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 RCW 48.43.735.

(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 284-43-5642, 284-43-5702, or 284-43-5782 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). The commissioner will approve health benefit

plans for offer in Washington state that are, at a minimum, consistent with current state law including, but not limited to, RCW 49.60.040, 49.60.178, 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 48.44.220, and 48.46.370 and with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557 including, but not limited to, those specifically found in 81 Fed. Reg. 31375, et seq. (2016), that were in effect on January 1, 2017.

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted under WAC 284-43-5642, 284-43-5702, and 284-43-5782.

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

(12) This section expires December 31, 2025.

#### NEW SECTION

**WAC 284-43-5624 Plan design.** (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2026, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-5644, 284-43-5704, and 284-43-5784.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2026, 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 284-43-5644, 284-43-5704, and 284-43-5784 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 practice as determined by Washington state law 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 RCW 48.43.735.

(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 284-43-5644, 284-43-5704, or 284-43-5784 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). The commissioner may approve health benefit plans for offer in Washington state that are, at a minimum, consistent with current state laws including, but not limited to, RCW 49.60.040, 49.60.178, 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 48.44.220, and 48.46.370 and with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557 including, but not limited to, those specifically found in 81 Fed. Reg. 31375, et seq. (2016), that were in effect on January 1, 2017.

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted under WAC 284-43-5644, 284-43-5704, and 284-43-5784.

AMENDATORY SECTION (Amending WSR 24-24-067, filed 11/27/24, effective 12/28/24)

**WAC 284-43-5642 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) Non-skilled 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 preven-

tive 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:

(A) Covered nutritional counseling; and

(B) Obesity-related services for which the U.S. Preventive Services Task Force for prevention and chronic care has issued A and B recommendations on or before the applicable plan year, which issuers must cover under subsection (9) of this section.

(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;
- (vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility;
- (vii) Inpatient hospitalization where mental illness is the primary diagnosis.

(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) 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;
- (ii) 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.
- (iii) Reversal of sterilizations; and
- (iv) 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. Health plans may not include the base-benchmark plan limitations listed below and must cover all services consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017, RCW 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 49.60.040 and 49.60.178:

- (i) The base-benchmark plan allows a waiting period for transplant services;
- (ii) The base-benchmark plan excludes coverage for sexual reassignment treatment, surgery, or counseling services; and
- (iii) The base-benchmark plan excludes coverage for hospitalization where mental illness or a substance use disorder is the primary diagnosis.

(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 coverage that is substantially equivalent to coverage for maternal care or services, as provided in RCW 48.43.073.

(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)* published by the American Psychiatric Association, 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 court-ordered mental health treatment that is not medically necessary as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing actuarial value for the category of mental health and substance use disorder services including behavioral 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, 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;

(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 30 day supplies at a time, other than insulin, which may be offered with more than a 30 day supply. This limitation is a floor, and an issuer may permit supplies greater than 30 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);

(iv) Reproductive health-related over-the-counter drugs, devices, and products approved by the federal Food and Drug Administration.

(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.

(iii) An issuer may include over-the-counter medications in its formulary for purposes of establishing quantitative limits and administering the benefit.

(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 as-

sist 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 requirements 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 30 service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to 25 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 has issued A and B recommendations on or before the applicable plan year.

(B) To the extent not specified in the relevant recommendation or guideline, federal rules and guidance related to preventive services in effect on January 8, 2024, and in chapter 284-43 WAC, a plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the provision of an item or service described in RCW 48.43.047;

(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 19, or covers dependent children age 19 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 an item or service described in RCW 48.43.047, including providing multiple prevention and screening services at a single visit or across multiple visits. Medical management techniques may not be used that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products approved by the federal Food and Drug Administration.

(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 establishes specific limitations on services classified to the preventive services category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans. Specifically, the base-benchmark plan excludes coverage for obesity or weight control other than covered nutritional counseling. Health plans must cover certain obesity-related services that are listed as A or B recommendations by the U.S. Preventive Services Task Force, consistent with RCW 48.43.047 and 45 C.F.R. 147.130 (a) (1) (i).

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Sec. 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) Each category of essential health benefits must at a minimum cover services required by current state law and be consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017.

(13) This section applies to health plans that have an effective date of January 1, 2020, or later.

(14) This section expires on December 31, 2025.

#### NEW SECTION

**WAC 284-43-5644 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;

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

(viii) Medically necessary routine foot care;

(ix) Acupuncture as medically necessary; and

(x) Preliminary evaluations and diagnosis to determine if and why a covered member is infertile and artificial insemination procedures.

(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, other than preliminary evaluations and diagnosis to determine if and why a covered member is infertile and artificial insemination;

(ii) Reversal of voluntary sterilization and those services referenced in (a)(vii) of this subsection;

(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) Non-skilled care and help with activities of daily living;

(vii) Obesity or weight reduction or control other than:

(A) Covered nutritional counseling; and

(B) Obesity-related services for which the U.S. Preventive Services Task Force for prevention and chronic care has issued A and B recommendations on or before the applicable plan year, which issuers must cover under subsection (9) of this section.

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

(iii) 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 or behavioral health emergency services provider and treatment provided as part of the ambulance service;

(ii) Emergency room and department based services, supplies and treatment and behavioral health emergency services provider 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. Detoxification services are an emergency service;

(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;

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

(vii) Inpatient hospitalization where mental illness is the primary diagnosis.

(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) 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;

(ii) 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;

(iii) Reversal of sterilizations; and

(iv) 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. Health plans may not include the base-benchmark plan limitations listed below and must cover all services consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017, RCW 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 49.60.040 and 49.60.178.

(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) Donor human milk for inpatient use when ordered by a licensed health care provider with prescriptive authority or an international board certified lactation consultant certified by the international board of lactation consultant examiners for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding, if the infant meets at least one of the criteria outlined in RCW 48.43.815;
- (vii) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and
- (viii) Termination of pregnancy coverage that is substantially equivalent to coverage for maternal care or services, as provided in RCW 48.43.073.

(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)* published by the American Psychiatric Association, 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 classi-

fy 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; and

(vi) Acupuncture treatment visits as medically necessary.

(b) A health benefit plan may, but is not required to, include court-ordered mental health treatment that is not medically necessary as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing actuarial value for the category of mental health and substance use disorder services including behavioral 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, 2026. 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, and insulin and insulin syringes;

(iii) All FDA-approved contraceptive methods, and prescription-based sterilization procedures;

(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 30 day supplies at a time, other than insulin, which may be offered with more than a 30 day supply. This limitation is a floor, and an issuer may permit supplies greater than 30 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);

(iv) Reproductive health-related over-the-counter drugs, devices, and products approved by the federal Food and Drug Administration.

(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.

(iii) An issuer may include over-the-counter medications in its formulary for purposes of establishing quantitative limits and administering the benefit.

(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

(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 is not 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 in 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 rehabilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.

(iv) Rehabilitative 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 rehabilitative 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 rehabilitative services.

(vi) An issuer must not exclude coverage for rehabilitative services received at a school-based health care center unless the rehabilitative 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 rehabilitative services category include:

(i) Inpatient rehabilitation facilities and professional services delivered in those facilities are limited to 30 service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy, and speech therapy are limited to 25 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 scan.

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

(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 19, or covers dependent children age 19 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 an item or service described in RCW 48.43.047, including providing multiple prevention and screening services at a single visit or across multiple visits. Medical management techniques may not be used that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products approved by the federal Food and Drug Administration.

(v) To the extent not specified in the relevant recommendation or guideline, federal rules and guidance related to preventive services and in chapter 284-43 WAC, a plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the provision of an item or service described in RCW 48.43.047;

(vi) 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

(vii) Wellness services.

(c) The base-benchmark plan establishes specific limitations on services classified to the preventive services category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans. Specifically, the base-benchmark plan excludes coverage for obesity or weight control other than covered nutritional counseling and certain obesity-related services that are listed as A or B recommendations by the U.S. Preventive Services Task Force, consistent with RCW 48.43.047 and 45 C.F.R. 147.130 (a) (1) (i).

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Sec. 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 (RCW 48.43.047);

(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.

(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) Each category of essential health benefits must, at a minimum, cover services required by current state law and be consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017.

(13) This section applies to health plans that have an effective date of January 1, 2026, or later.

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

**WAC 284-43-5702 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~~) 19. Plans must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age (~~nineteen~~) 19.

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

(2) The requirements of WAC 284-43-5642 and 284-43-5782 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 284-43-5642 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 WW0114BPP01SD, 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~~) 12-month period for ages six and under; two times in a (~~twelve~~) 12-month period for ages seven and older; and three times in a (~~twelve~~) 12-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~~) 12 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~~) 13 and older;
  - (q) Periodontal maintenance once per quadrant in a (~~twelve~~) 12-month period for ages (~~thirteen~~) 13 and older;
  - (r) Stainless steel crowns for primary anterior teeth once every three years, if age (~~thirteen~~) 13 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~~) 12 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) Rebasings 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.

(8) This section expires December 31, 2025.

#### NEW SECTION

**WAC 284-43-5704 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 19. Plans must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age 19.

(1) For benefit years beginning January 1, 2026, 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 (4) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-5644 and 284-43-5784 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 284-43-5644 and covers pediatric oral services. The designated base-benchmark plan for pediatric dental benefits consists of the benefits and services covered within Appendix B - Washington Essential Health Benefits Benchmark Plan and Appendix C - State EHB Benchmark Summary of Benefits as approved by the department of health and human services Centers for Medicare and Medicaid Services on October 7, 2024, as available on the commissioner's website.

(a) Pediatric preventive and diagnostic dental services.

(i) Bitewing x-rays;

- (ii) Cephalometric films;
- (iii) Complete intra-oral mouth x-rays;
- (iv) Diagnostic casts when dentally appropriate;
- (v) Limited oral evaluations to evaluate the member for a specific dental problem or oral health complaint, dental emergency, or referral for other treatment;
- (vi) Limited visual oral assessments or screenings not performed in conjunction with other clinical oral evaluation services;
- (vii) Occlusal intraoral x-rays;
- (viii) Oral hygiene instruction if not billed on the same day as a cleaning;
- (ix) Periapical x-rays that are not included in a completed series for diagnosis in conjunction with definitive treatment;
- (x) Photographic images (oral and facial) when dentally appropriate;
- (xi) Periodic and comprehensive oral examinations, limited to two per member per calendar year, beginning before one year of age;
- (xii) Problem focused oral examinations;
- (xiii) Panoramic mouth x-rays;
- (xiv) Cleanings, limited to two per member per calendar year;
- (xv) Sealants;
- (xvi) Space maintainers (fixed unilateral or fixed bilateral), subject to the following limits:
  - (A) Recementation of space maintainers;
  - (B) Removal of space maintainers; and
  - (C) Replacement space maintainers are covered when dentally appropriate.
- (xvii) Topical fluoride application when dentally appropriate.
- (b) Basic dental services.
  - (i) Complex oral surgery procedures including:
    - (A) Surgical extractions of teeth;
    - (B) Impactions;
    - (C) Alveoloplasty;
    - (D) Vestibuloplasty;
    - (E) Residual root removal;
    - (F) Frenulectomy;
    - (G) Frenuloplasty.
  - (ii) Emergency treatment for pain relief.
  - (iii) Endodontic services consisting of:
    - (A) Apexification for apical closures of anterior permanent teeth;
    - (B) Apicoectomy;
    - (C) Debridement;
    - (D) Direct pulp capping;
    - (E) Pulpal therapy;
    - (F) Pulp vitality tests;
    - (G) Pulpotomy; and
    - (H) Root canal treatment.
  - (iv) Endodontic benefits will not be provided for indirect pulp capping.
  - (v) Fillings consisting of composite and amalgam restorations, limited to the following:
    - (A) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars;
    - (B) A maximum of six surfaces per tooth for teeth one, two, three, 14, 15, and 16;

- (C) A maximum of six surfaces per tooth for permanent anterior teeth;
- (D) Restorations on the same tooth are limited to once in a two-year period; and
- (E) Two occlusal restorations for the upper molars on teeth one, two, three, 14, 15, and 16.
- (vi) General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth. Other services related to general anesthesia or intravenous sedations are covered as follows:
  - (A) Drugs and/or medications only when used with parenteral conscious sedation, deep sedation, or general anesthesia;
  - (B) Inhalation of nitrous oxide, once per day; and
  - (C) Local anesthesia and regional blocks, including office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia.
- (vii) Periodontal services consisting of:
  - (A) Complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
  - (B) Debridement limited to once per member in a three-year period;
  - (C) Gingivectomy and gingivoplasty limited to once per member per quadrant in a three-year period;
  - (D) Periodontal maintenance limited to once per quadrant in a calendar year; and
  - (E) Scaling and root planning limited to once per member per quadrant in a two-year period.
- (viii) Uncomplicated oral surgery procedures including removal of teeth, incision, and drainage.
- (c) Major dental services.
  - (i) Adjustments and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion;
  - (ii) Behavior management;
  - (iii) Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement;
  - (iv) Crowns and crown build-ups, limited to the following:
    - (A) An indirect crown in a five-year period, per tooth, for permanent anterior teeth for members with fully erupted permanent anterior teeth;
    - (B) Cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;
    - (C) Core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;
    - (D) Recommendations of permanent indirect crowns for members with fully erupted permanent anterior teeth;
    - (E) Stainless steel crowns for primary posterior teeth once in a three-year period; and
    - (F) Stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17, and 32) once in a three-year period.
  - (v) Dental implant crown and abutment related procedures, limited to one per member per tooth in a seven-year period;
  - (vi) Dentures, full and partial, including:
    - (A) Denture rebase, limited to one per member per arch in a three-year period, if performed at least six months from the seating date;

(B) Denture relines, limited to one per member per arch in a three-year period, if performed at least six months from the seating date;

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

(D) One resin-based partial denture, replaced once within a three-year period.

(vii) Home visits, including extended care facility calls, limited to two calls per facility per provider;

(viii) Medically necessary orthodontic services for members with malocclusions associated with:

(A) Cleft lip and palate, cleft palate, and cleft lip with alveolar process involvement; and

(B) Craniofacial anomalies for hemifacial microsomia, cranosynostosis syndromes, anthrogyrposis, or Marfan syndrome.

(ix) Occlusal guards;

(x) Post-surgical complications;

(xi) Repair of crowns is limited to one per tooth;

(xii) Repair of implant supported prosthesis or abutment, limited to one per tooth.

(5) An issuer must supply pediatric dental exclusions in a manner substantially equal to the base-benchmark plan.

(6) Pediatric dental plans must categorize covered dental services in a manner consistent with the essential health benefit benchmark plan (i.e., preventative and diagnostic services, basic services, major services, etc.).

(7) 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.

(8) This section applies to health plans that have an effective date of January 1, 2026, or later.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

**WAC 284-43-5782 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 WW0114BPP01SD, 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~~) 19:

(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.

(6) This section expires December 31, 2025.

#### NEW SECTION

**WAC 284-43-5784 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 within Appendix B - Washington Essential Health Benefits Benchmark Plan and Appendix C - State EHB Benchmark Summary of Benefits as approved by the

department of health and human services Centers for Medicare and Medicaid Services on October 7, 2024, as available on the commissioner's website.

(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 19:

(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;

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

(iii) Follow-up care of four visits.

(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, 2026, or later.

AMENDATORY SECTION (Amending WSR 23-24-034, filed 11/30/23, effective 1/1/24)

**WAC 284-43-5937 Hearing instrument coverage.** (1) The purpose of this regulation is to effectuate the provisions of chapter 245, Laws of 2023, by requiring health carriers to include coverage for hearing instruments.

(2) This section applies to health carriers offering nongrandfathered group health plans, other than small group health plans, issued or renewed on or after January 1, 2024.

(3) The hearing instruments and coverage requirements referenced in this section have the same meaning as in RCW 48.43.135.

(4) Health carriers shall provide in network coverage for hearing instruments at no less than \$3,000 per ear with hearing loss every 36 months. Any enrollee cost-sharing applied to this coverage must ensure that the amount paid by the health plan will be no less than \$3,000 except to the extent required otherwise in RCW 48.43.135(4).

(5) Enrollees can purchase a hearing instrument beyond the cost limitations outlined in this section and coverage must still be provided at no less than \$3,000 per ear with hearing loss every 36 months.

(6) The 36-month time period referenced in this section and RCW 48.43.135(3), is specific to the enrollee's current health carrier.

(7) This section expires December 31, 2025.

NEW SECTION

**WAC 284-43-5939 Hearing instrument coverage.** (1) For purposes of compliance with RCW 48.43.135 and WAC 284-43-5644, which require health plans issued or renewed on or after January 1, 2026, to cover hearing instruments and related services:

(a) "Hearing instrument" has the same meaning as defined in RCW 48.43.135;

(b) "Initial assessment" means the same as "hearing screening" per the American Speech-Language-Hearing Association and basic hearing evaluation tests conducted as found in the current procedural terminology;

(c) "Over-the-counter hearing instrument" has the same meaning as defined in RCW 48.43.135; and

(d) "Annual hearing exam" means the same as hearing evaluation per the American Speech-Language-Hearing Association and comprehensive hearing evaluation tests conducted as found in the current procedural terminology.

(2) A health carrier shall provide in-network coverage for hearing instruments every 36 months per ear with hearing loss and may not establish any lifetime or annual limit on the dollar amount of coverage for services for any individual, whether provided in-network or out-of-network.

(3) In addition to coverage of hearing instruments, health carriers shall provide coverage of an initial assessment, annual hearing exams, fitting, adjustment, auditory training, and ear molds as necessary to ensure optimal fit. Coverage of over-the-counter hearing instruments is not required.

(4) The 36-month time period referenced in subsection (2) of this section and RCW 48.43.135 is specific to the enrollee's current health carrier.

(5) The services and hearing instruments covered under this section are not subject to the enrollee's deductible unless the health plan is offered as a qualifying health plan for a health savings account. For such a qualifying health plan, the carrier may apply a deductible to coverage of the services covered under this section only at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations.

#### REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 284-43-5600	Essential health benefits package benchmark reference plan.
WAC 284-43-5620	Plan design.
WAC 284-43-5640	Essential health benefit categories.
WAC 284-43-5700	Essential health benefit category— Pediatric oral services.
WAC 284-43-5780	Pediatric vision services.

#### **RDS-6762.1**

AMENDATORY SECTION (Amending WSR 20-24-040, filed 11/23/20, effective 12/24/20)

**WAC 284-43-7010 Definitions. Aggregate lifetime limit** means a dollar limitation on the total amount of specified benefits that may be paid under a plan (or health insurance coverage offered in connection with a plan) for any coverage unit.

**Annual dollar limit** means a dollar limitation on the total amount of specified benefits that may be paid in a (~~twelve~~) 12-month period under a plan (or health insurance coverage offered in connection with a plan) for any coverage unit.

**Approved treatment program** means a discrete program of substance use disorder treatment provided by a treatment program certified by the department of health as meeting standards adopted under chapter 71.24 RCW.

**Classification of benefits** means a group into which all medical/surgical benefits and mental health or substance use disorder benefits offered by a plan must fall. For the purposes of this rule, the only classifications that may be used are: Inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.

**Coverage unit** means the way in which a plan or issuer groups individuals for purposes of determining benefits, or premiums or contri-

butions. For example, different coverage units include self-only, family, and employee-plus-spouse.

**Cumulative financial requirements** means financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

**Cumulative quantitative treatment limitations** means treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

**Emergency condition, for the purpose of this subchapter,** means a medical, mental health or substance use disorder condition manifesting itself by acute symptoms of sufficient severity, including severe emotional or physical distress or a combination of severe emotional and physical distress, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health or substance use disorder treatment attention to result in a condition placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

**Essential health benefits (EHBs).** EHBs have the same definition as found in WAC (~~((284-43-5600-01))~~) 284-43-5602 or 284-43-5604, as appropriate. The definition of EHBs includes mental health and substance use disorder services, including behavioral health treatment. For EHBs, including mental health and substance use disorder benefits, federal and state law prohibit limitations on age, condition, lifetime and annual dollar amounts.

**Financial requirements** means cost sharing measures such as deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

**Health carrier or issuer** has the same meaning as RCW 48.43.005(~~((+25))~~).

**Health plan** has the same meaning as RCW 48.43.005(~~((+26))~~).

**Medical/surgical benefits** means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *International Classification of Diseases* (ICD) or state guidelines).

**Medically necessary or medical necessity:**

(a) With regard to substance use disorder is defined by the most recent version of *The ASAM Criteria, Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions* as published by the American Society of Addiction Medicine (ASAM).

(b) With regard to mental health services, pharmacy services, and any substance use disorder benefits not governed by ASAM, is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

**Mental health benefits** means benefits with respect to items or services for mental health and substance use disorder conditions, as

defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being a mental health condition must be defined to be consistent with the most current version of the *Diagnostic and Statistical Manual of Mental Disorders*, as published by the American Psychiatric Association.

**Nonquantitative treatment limitations (NQTL)** means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to:

- (a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- (b) Formulary design for prescription drugs;
- (c) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- (d) Standards for provider admission to participate in a network, including reimbursement rates;
- (e) Plan methods for determining usual, customary, and reasonable charges;
- (f) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- (g) Exclusions based on failure to complete a course of treatment; and
- (h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

**Plan** means a health plan, a short-term limited duration medical plan or a student-only health plan.

**Predominant level:** If a type of financial requirement or quantitative treatment limitation applies to substantially all medical surgical benefits in a classification, the predominant level is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

**Quantitative parity analysis** means a mathematical test by which plans and issuers determine what level of a financial requirement or quantitative treatment limitation, if any, is the most restrictive level that could be imposed on mental health or substance use disorder benefits within a classification.

**Quantitative treatment limitations** means types of objectively quantifiable treatment limitations such as frequency of treatments, number of visits, days of coverage, days in a waiting period or other similar limits on the scope or duration of treatment.

**Short-term limited duration medical plan** means a plan deemed by the commissioner to have a short-term limited purpose or duration.

**Student-only health plan** means a health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution.

**Substance use disorder** means a substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

**Substance use disorder benefits** means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with

applicable federal and state law. Substance use disorder benefits must include payment for reasonable charges for medically necessary treatment and supporting service rendered to an enrollee either within an approved treatment program or by a health care professional that meets the requirements (~~(of RCW 18.205.040(2),~~) as part of the approved treatment plan.

**Substantially all:** A type of financial requirement or quantitative treatment limitation considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification as determined by WAC 284-43-7040 (2) (a).

**Treatment limitations** means limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as (~~fifty~~) 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this section.

#### RDS-6763.1

AMENDATORY SECTION (Amending WSR 21-24-032, filed 11/22/21, effective 12/23/21)

**WAC 284-43-7210 Definitions.** (1) "Contraceptive services" means consultations, examinations, procedures, and other health care services to obtain contraceptive supplies or voluntary sterilization. This includes prescribing, dispensing, inserting, delivering, distributing, administering, or removing contraceptive supplies and voluntary sterilization procedures.

(2) "Contraceptive supplies" means all contraceptive drugs, devices, and other products approved by the Federal Food and Drug Administration. This includes over-the-counter contraceptive drugs, devices, and products approved by the Federal Food and Drug Administration.

(3) "Cost-sharing" means any expenditure required of a covered person for covered services or supplies, including applicable taxes. Cost-sharing includes deductibles, coinsurance, copayments, or similar charges. Cost-sharing does not include premiums, balance billing amounts for nonnetwork providers, or spending for noncovered services or supplies.

(4) "Covered person" or "enrollee" has the same meaning as defined in RCW 48.43.005.

(5) "Gender expression" has the same meaning as defined in RCW 48.43.072.

(6) "Gender identity" has the same meaning as defined in RCW 48.43.072.

(7) "Medical management" or "medical management techniques" has the same meaning as defined in RCW 48.165.010.

(8) "Reproductive health care services" has the same meaning as defined in RCW 48.43.072.

(9) "Reproductive system" has the same meaning as defined in RCW 48.43.072.

(10) "Well-person preventative visits" has the same meaning as defined in RCW 48.43.072.

(11) "Prescription hormone therapy" has the same meaning as defined in RCW 48.43.845.

## RDS-6764.1

AMENDATORY SECTION (Amending WSR 24-24-065, filed 11/27/24, effective 12/28/24)

**WAC 284-43B-029 Local governmental entity rate reporting to the insurance commissioner.** (1) Each local governmental entity that has established rates for ground ambulance services provided in their geographic area must submit the rates to the office of the insurance commissioner in the form and manner prescribed by the commissioner. Rates established for ground ambulance transports include rates for services provided directly by the local governmental entity and contracted rates.

(2) Local governmental entities must include the following rate information in their submission to the commissioner for each locally set rate or contracted rate submitted to the commissioner:

(a) The local governmental entity's full legal name and address;

(b) The national provider identifier(s) (NPI) for any ground ambulance services organization to which the rate applies;

(c) The effective date of the rate and any known expiration date of the rate;

(d) The service area of the local governmental entity, described by listing the geographic zone improvement plan (ZIP) codes established by the United States Postal Service that are included in the entity's service area;

(e) The applicable transport codes to which the rate applies, including any separate mileage code or codes;

(f) If applicable, the locally set rate for services provided to nonresidents of the local governmental entity's service area, if a distinction is made in rates between services provided to residents and those provided to nonresidents.

(3) The information must be submitted electronically through the website of the office of the insurance commissioner.

(4) Local governmental entities must submit their rates to the commissioner on the following schedule:

(a) Updated rates must be submitted by November 1st for an effective date of January 1st of the following year.

(b) A rate may be updated by a local governmental entity outside of the time frame established in (a) of this subsection if the local governmental entity finds that there is an emergent risk to the financial viability of the public ground ambulance services organization if the rate update is delayed to a January 1st effective date. To apply for rate update exception a local governmental entity must:

(i) Follow their local rate setting rules and procedures and be approved in the manner prescribed by their governing entity.

(ii) Allow 60 days from approval of the new rate to its effective date.

(iii) Submit the updated rate and documentation of the local governing entity's approval of new rate to the office of the insurance commissioner at least 30 days prior to its effective date.

(5) For purposes of this section "contracted rates" means rates established in a contract or contracts between a local governmental entity and a private ground ambulance services organization to provide ground ambulance services in their geographic service area.