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-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 contributions. 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 or 284-43-5602, 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 un-

der 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 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.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7010, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-7010, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-7010, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-991, filed 11/17/14, effective 12/18/14.]