

WAC 284-43-5640 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services." For purposes of determining a plan's actuarial value, an issuer must classify as ambulatory patient services medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, in a substantially equal manner to the base-benchmark plan.

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

(i) Home and outpatient dialysis services;

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

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

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

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

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

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

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

(i) Infertility treatment and reversal of voluntary sterilization;

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

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

(A) Emergency in nature; or

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

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

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

(vi) 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, other than for cochlear implants, which are covered, and for hearing screening tests required under the preventive services category, unless coverage for these services and devices are required as part of, and classified to, another essential health benefits category;

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

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

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

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

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

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

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

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

(i) Chiropractic care (RCW 48.44.310);

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

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

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

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

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

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

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

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

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

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

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

(3) A health benefit plan must cover "hospitalization." For purposes of determining a plan's actuarial value, an issuer must classify

as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis, in a substantially equal manner to the base-benchmark plan.

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

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

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

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

(iv) Dialysis services delivered in a hospital;

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

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

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

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

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

(iii) The following types of surgery:

(A) Bariatric surgery and supplies;

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

(C) Sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

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

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

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

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

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

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

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

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

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

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

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

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

(i) In utero treatment for the fetus;

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

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

(iv) Infertility diagnosis;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

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

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

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

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

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

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

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

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

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

(ii) Chemical detoxification coverage must not be uniformly limited to thirty days. Medical necessity, utilization review and criteria

consistent with federal law may be applied by an issuer in designing coverage for this benefit;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Weight loss drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Cochlear implants;

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

- (iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;
 - (iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;
 - (v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.
- (c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:
- (i) Off the shelf shoe inserts and orthopedic shoes;
 - (ii) Exercise equipment for medically necessary conditions;
 - (iii) Durable medical equipment that serves solely as a comfort or convenience item; and
 - (iv) Hearing aids other than cochlear implants.
- (d) **Supplementation:** The base-benchmark plan does not cover certain federally required services under this category. A health benefit plan must cover habilitative services, but these services are not specifically covered in the base-benchmark plan. Therefore, this category is supplemented. The state EHB-benchmark plan requirements for habilitative services are:
- (i) For purposes of determining actuarial value and complying with the requirements of this section, the issuer must classify as habilitative services and provide coverage for the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping or learning age appropriate skills and functioning within the individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness.
 - (ii) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include reference based limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.
 - (iii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all of the services in a plan of treatment are provided by a public or government program.
 - (iv) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.
 - (v) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.
 - (vi) Consistent with the standards in this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) A health plan must cover "preventive and wellness services, including chronic disease management." For purposes of determining a

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

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

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

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

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

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

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

(vi) Wellness services.

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

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

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

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

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

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

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

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

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

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

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

[WSR 16-01-081, recodified as § 284-43-5640, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-878, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-15-012 (Matter No. R 2014-03), § 284-43-878, filed 7/3/14, effective 7/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-878, filed 7/9/13, effective 7/10/13.]