§ 156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of § 156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under § 156.110(a)(5) of this subpart, comply with the requirements of § 146.136 of this subchapter.

(4) Include preventive health services described in § 147.130 of this subchapter.

(5) If the EHB-benchmark plan does not include coverage for habilitative services, as described in § 156.110(f) of this subpart, include habilitative services in a manner that meets one of the following—

(i) Provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or

(ii) Is determined by the issuer and reported to HHS.

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;

(ii) Is made only within the same essential health benefit category; and

(iii) Is not a prescription drug benefit.

(2) Submits evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined regardless of cost-sharing.

(c) A health plan does not fail to provide EHB solely because it does not offer the services described in § 156.280(d) of this subchapter.

(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

§ 156.122 Prescription drug benefits.

(a) A health plan does not provide essential health benefits unless it:

(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

(i) One drug in every United States Pharmacopeia (USP) category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the Exchange, the State, or OPM.

(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the Food and Drug Administration as a service described in § 156.280(d) of this subchapter.

(c) A health plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.

(1) Such procedures must include a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances.

(i) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(ii) A health plan must make its coverage determination on an expedited