OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Benefits for Health Care Coverage

Washington Benchmark Plan
March 29, 2024

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I. At a Glance – Covered and Not Covered

Disclaimer:

The following Washington Essential Health Benefits (EHB) Benchmark Plan is provided as a summary of covered services and supplies in major medical health insurance coverage in Washington beginning in Plan Year 2026. This EHB Benchmark Plan is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not.

Nothing in this 2026 Benchmark plan should be construed as additional EHB requirements under Federal Law. At no time shall the set of benefits listed below be construed to allow an issuer to NOT cover any and all federal and state required benefits.

To the extent that the Benchmark Plan does not comply with federal requirements, including the mental health parity and addiction equity act (MHPAEA), carriers offering individual and small group health plans must conform benefits to meet all applicable federal and state requirements when designing plans that are substantially equal to the Benchmark Plan. This includes ensuring that the availability of benefits is not discriminatory under state and federal law.

A list of the services covered and not covered, and any relevant exclusions, is listed in Appendix B.

II. Detail of Benefits

Benefits are listed alphabetically, with the exception of the Preventive Care and Immunizations, Office Visits and Other Professional Services benefits.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive care services provided by a professional Provider or facility are covered. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, United States Food and Drug Administration (FDA) approved contraceptive devices and implants including the insertion and removal of those devices or implants, immunizations, health screening sand other preventive services for adults and children as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco cessation. See the Prescription Medications benefit for a description of how to obtain Generic Medications. Coverage for all such services is provided only for preventive care.

OFFICE VISITS – ILLNESS OR INJURY

Office visits for treatment of Illness or Injury are covered. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (separate facility fees billed in conjunction with the office visit for example) are not considered an office visit under this provision. For example, a surgical procedure performed in the office according to the Other Professional Services benefit is covered.

OTHER PROFESSIONAL SERVICES

Services and supplies provided by a professional Provider subject to any specified limits as explained in the following paragraphs are covered:

Medical Services

Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury are covered.

Professional Inpatient
Professional inpatient visits for Illness or Injury are covered.

Radiology and Laboratory
Services for treatment of Illness or Injury, including genetic testing, are covered. This includes, but is not limited to, mammography and prostate screening services not covered under the Preventive Care and Immunizations benefit. Radiology services include X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.

Diagnostic Procedures
Services for diagnostic procedures including but not limited to colonoscopies, cardiovascular testing, pulmonary function studies, sleep studies and neurology/neuromuscular procedures are covered.

Surgical Services
Surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist, including coverage of cochlear implants are covered.

Therapeutic Injections
Therapeutic injections and related supplies when given in a professional Provider's office are covered.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit. Teaching doses (by which a Provider educates the Member to self-inject) are covered for this list of Self-Administrable Injectable Medications up to a limit of three doses per medication per Member Lifetime.

ACUPUNCTURE
Acupuncture services are covered when provided by a professional Provider as medically necessary.

AMBULANCE SERVICES
Ambulance transport services to the nearest Hospital or behavioral health emergency services provider for those experiencing an Emergency Medical Condition and the purpose of the transportation is not for personal or convenience purposes are covered. Covered ambulance services include licensed ground and air ambulance Providers.

BLOOD BANK
The services and supplies of a blood bank are covered.

DENTAL HOSPITALIZATION
Inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia) are covered. Benefits are not available for the charges of a dentist or for services received in a dentist's office.

DETOXIFICATION
Medically Necessary detoxification services as an Emergency Medical Condition are covered and do not require pre-authorization or pre-notification. You may choose to see an In- Network or Out-of-Network Provider for the provision of detoxification services.

DIABETIC EDUCATION
Services and supplies for diabetic self-management training and education, including nutritional therapy are covered.

DIABETES SUPPLIES AND EQUIPMENT
Supplies and equipment for the treatment of diabetes are covered. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medications benefits for coverage details of such covered supplies and equipment.

DIALYSIS
Inpatient and outpatient, including home-based, services and supplies for dialysis are covered. You may choose to see an In- Network or Out-of-Network Provider for the provision of dialysis services. See the Definitions Section of this Contract for a complete description of In-Network and Out-of-Network Providers.

DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Member's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item. Coverage includes sales tax under this benefit for Durable Medical Equipment and mobility enhancing equipment, that is a Covered Service and when such equipment is not otherwise tax exempt.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)
Emergency room services and supplies are covered, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized. You may choose to see an In- Network or Out-of-Network Provider for emergency room services. See the Hospital Care benefit for coverage of inpatient Hospital admissions.

FAMILY PLANNING
Certain professional Provider contraceptive services and supplies are covered, including, but not limited to, vasectomy under this benefit.

For coverage of prescription contraceptives, please see the Prescription Medications benefit.

FOOT CARE (ROUTINE)
Routine foot care, including, but not limited to: treatment of corns and calluses, trimming of nails, and foot care appliances for prevention of complications associated with a medical condition is covered as medically necessary.

HABILITATIVE SERVICES
Medically Necessary inpatient and outpatient health care services are covered, including speech therapy, occupational therapy, physical therapy and aural therapy, and devices approved by the United States FDA that are designed to assist the Member in partially or fully developing, keeping and learning age-appropriate skills and functioning, within the Member's environment or to compensate for the Member's progressive physical, cognitive and emotional illness. Chore services to assist with basic needs, vocational or custodial services are not classified as Habilitative Services and are not covered. Inpatient services are limited to a maximum of 30 days per Member per Calendar Year. Outpatient services are limited to a maximum of 25 visits per Member per Calendar Year.

HEARING INSTRUMENTS
Coverage is included for Hearing Instruments, including bone conduction hearing devices. Coverage also shall include the initial assessment, fitting, adjustment, auditory training, and ear molds as necessary to maintain optimal fit. Coverage includes services for enrollees who intend to obtain or have already obtained any hearing instrument, including an over-the-counter hearing instrument. Coverage of hearing instruments is limited to one hearing instrument per year every three years.

HOME HEALTH CARE
Home health care is covered when provided by a licensed agency or facility for home health care to a maximum of 130 visits per Member per Calendar Year. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Durable Medical Equipment associated with home health services is covered under the Durable Medical Equipment benefit.

HOSPICE CARE
Hospice care for terminally ill members is covered when provided by a licensed hospice care program. The only hospice limit is a maximum of 14 inpatient or outpatient respite days per lifetime A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These covered services include acute, respite and home care to meet the physical, psychosocial, and special needs of a patient and his or her family during the final stages of Illness. Respite care to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member is covered. Durable Medical Equipment is covered under this benefit when billed by a licensed hospice care program. For a definition of Durable Medical Equipment, see the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SERVICE FACILITY
Inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Service Facility for Injury and Illness (including services of staff providers billed by the Hospital) are covered. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. See the Emergency Room benefit for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

INFERTILITY TREATMENT
Evaluations to determine if and why a covered member is infertile are covered. Artificial insemination procedures are covered.

The following infertility services are excluded:

All Services and supplies (other than artificial insemination) related to conception by artificial means. Prescription drugs related to such Services, and donor semen and donor eggs used for such Services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.

MATERNITY CARE
Prenatal and postnatal maternity (pregnancy) care, including screening, childbirth (vaginal or cesarean) in a hospital, birthing center or at home, for low risk pregnancies, complications of pregnancy, and related conditions for all female Members (including eligible dependents of dependents who have enrolled under this Contract), including diagnosis of infertility, are covered. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy for all female Members.

MEDICAL FOODS (PKU)
Medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU) are covered.

MENTAL HEALTH SERVICES
Mental Health Services for treatment of Mental Health Conditions are covered.

Definitions
In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health Services benefit:

Mental health Conditions means mental health disorders included in the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association.

Mental Health Services means Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined to not be Medically Necessary).

Residential Care means care received in an organized program that is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

NEURODEVELOPMENTAL THERAPY

Inpatient and outpatient neurodevelopmental therapy services are covered. Outpatient neurodevelopmental therapy services are limited to a maximum of 25 outpatient visits per Member per Calendar Year.

Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, as medically necessary. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child are covered. There is no limit for the newborn's length of inpatient stay. For the purpose of this benefit, "newborn care" means the medical services provided to a newborn child following birth including well-baby Hospital nursery charges, the initial physical examination and a PKU test.

Donor Human Milk
Coverage is available for medically necessary 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:

- An infant birth weight of below 2,500 grams;
- An infant gestational age equal to or less than 34 weeks;
- Infant hypoglycemia;
- A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity;
- A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications;
- Congenital heart disease requiring surgery in the first year of life;
- An organ or bone marrow transplant;
- Sepsis;
- Congenital hypotonias associated with feeding difficulty or malabsorption;
- Renal disease requiring dialysis in the first year of life;
- Craniofacial anomalies;
- An immunologic deficiency;
- Neonatal abstinence syndrome;

- Any other serious congenital or acquired condition for which the use of pasteurized donor human milk and donor human milk derived products is medically necessary and supports the treatment and recovery of the child; or
- Any baby still inpatient within 72 hours of birth without sufficient human milk available

NUTRITIONAL COUNSELING
Nutritional counseling is covered and not subject to any specific visit limitation.

ORTHOTIC DEVICES
Benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body are covered. Off-the-shelf shoe inserts and orthopedic shoes are not covered.

PEDIATRIC DENTAL
Pediatric Dental Services are covered for pediatric members as defined by the ACA.

Pediatric Preventive And Diagnostic Dental Services
The following preventive and diagnostic Dental Services are covered for pediatric patients as defined by the ACA:

- Bitewing x-rays.
- Cephalometric films.
- Complete intra-oral mouth x-rays.
- Diagnostic casts when Dentally Appropriate.
- Limited oral evaluations to evaluate the Member for a specific dental problem or oral health complaint, dental emergency or referral for other treatment.
- Limited visual oral assessments or screenings not performed in conjunction with other clinical oral evaluation services.
- Occlusal intraoral x-rays.
- Oral hygiene instruction if not billed on the same day as a cleaning.
- Periapical x-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment.
- Photographic images (oral and facial) when Dentally Appropriate.
- Periodic and comprehensive oral examinations.
- Problem focused oral examinations.
- Panoramic mouth x-rays.
- Cleanings.
- Sealants.
- Space maintainers (fixed unilateral or fixed bilateral), subject to the following limits:
    - re-cementation of space maintainers,
    - removal of space maintainers, and
    - replacement space maintainers are covered when Dentally Appropriate.
- Topical fluoride application when Dentally Appropriate.

Basic Dental Services
The following basic Dental Services are covered for pediatric patients as defined by the ACA:

- Complex oral surgery procedures including:
    - surgical extractions of teeth
    - impactions
    - alveoloplasty
    - vestibuloplasty

- residual root removal
- frenulectomy
- frenuloplasty.

- Emergency treatment for pain relief.

- Endodontic services consisting of:

  - apexification for apical closures of anterior permanent teeth;
  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulp vitality tests;
  - pulpotomy; and
  - root canal treatment.

- Endodontic benefits will **not** be provided for:

  - indirect pulp capping.

- Fillings consisting of composite and amalgam restorations, limited to the following:

  - a maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars;
  - a maximum of six surfaces per tooth for teeth one, two, three, 14, 15 and 16;
  - a maximum of six surfaces per tooth for permanent anterior teeth;
  - restorations on the same tooth are limited to once in a two-year period; and
  - two occlusal restorations for the upper molars on teeth one, two, three, 14, 15 and 16.

- 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 sedation are covered as follows:

  - drugs and/or medications only when used with parenteral conscious sedation, deep sedation, or general anesthesia;
  - inhalation of nitrous oxide, once per day; and
  - local anesthesia and regional blocks, including office-based oral or parenteral conscious sedation, deep sedation or general anesthesia.

- Periodontal services consisting of:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
  - debridement limited to once per Member in a three-year period;
  - gingivectomy and gingivoplasty limited to once per Member per quadrant in a three-year period;
  - periodontal maintenance limited to once per quadrant in a Calendar Year; and
  - scaling and root planning limited to once per Member per quadrant in a two-year period.

- Uncomplicated oral surgery procedures including removal of teeth, incision, and drainage.

Major Dental Services

The following major Dental Services are covered for pediatric patients as defined by the ACA:

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.
- Behavior management.
- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement.

- Crowns and crown build-ups, limited to the following:
    - an indirect crown in a five-year period, per tooth, for permanent anterior teeth for Members 12 years of age and older;
    - cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;
    - core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;
    - recommendations of permanent indirect crowns for Members 12 years of age and older;
    - stainless steel crowns for primary posterior teeth once in a three-year period; and
    - stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17 and 32) once in a three-year period.
- Dental implant crown and abutment related procedures, limited to one per Member per tooth in a seven-year period.
- Dentures, full and partial, including:
    - denture rebase, limited to one per Member per arch in a three-year period, if performed at least six months from the seating date;
    - denture relines, limited to one per Member per arch in a three-year period, if performed at least six months from the seating date;
    - one complete upper and lower denture, and one replacement denture after at least five years from the seat date; and
    - one resin-based partial denture, replaced once within a three-year period.
- Home visits, including extended care facility calls, limited to two calls per facility per provider.
- Medically Necessary orthodontic services for Members with malocclusions associated with:
    - cleft lip and palate, cleft palate and cleft lip with alveolar process involvement; and
    - craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, anthrogryposis or Marfan syndrome.
- Occlusal guards.
- Post-surgical complications.
- Repair of crowns is limited to one per tooth.
- Repair of implant supported prosthesis or abutment, limited to one per tooth.

DENTAL EXCLUSIONS

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Pediatric Dental benefit:

- **Aesthetic Dental Procedures**
    - Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- **Antimicrobial Agents**
    - Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- **Collection of Cultures and Specimens**
- **Connector Bar or Stress Breaker Cosmetic/Reconstructive Services and Supplies**
    - Cosmetic and/or reconstructive services and supplies are not covered unless deemed medically necessary by a licensed dental provider.

- Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).

- Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

- **Desensitizing**
  - Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

- **Duplicate X-Rays**

- **Fractures of the Mandible (Jaw)**
  - Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

- **Gold-Foil Restorations**

- **Implants**
  - Services and supplies provided in connection with implants, whether or not the implant itself is covered, including, but not limited to:

    - endodontic endosseous implants;
    - interim endosseous implants;
    - eposteal and transosteal implants;
    - sinus augmentations or lift;
    - implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
    - radiographic/surgical implant index; and
    - unspecified implant procedures.

- **Interim Partial or Complete Dentures**

- **Medications and Supplies**
  - Except as specifically provided in this Pediatric Dental benefit, charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies are not covered.

- **Occlusal Treatment**
  - Except as specifically provided in this Pediatric Dental benefit, services and supplies provided in connection with dental occlusion, including occlusal analysis and adjustments are not covered.

- **Oral Surgery**
  - Oral surgery treating any fractured jaw and orthognathic surgery. “Orthognathic surgery," refers to surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

- **Orthodontic Dental Services**
  - Except as specifically provided in this Pediatric Dental benefit, services and supplies provided in connection with orthodontics are not covered. The following services are not covered:

    - correction of malocclusion;
    - craniomandibular orthopedic treatment;
    - other orthodontic treatment;
    - preventive orthodontic procedures; and

    - procedures for tooth movement, regardless of purpose.

- **Precision Attachment**

- **Provisional Splinting**

- **Replacements**
  - Except as specifically provided under this Pediatric Dental benefit, services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken are not covered.

- **Separate Charges**
  - Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:
    - any supplies;
    - local anesthesia; and
    - sterilization.

- **Services Performed in a Laboratory**

- **Surgical Procedures**
  - Services and supplies provided in connection with the following surgical procedures:
    - exfoliative cytology sample collection or brush biopsy;
    - incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
    - radical resection of maxilla or mandible;
    - removal of nonodontogenic cyst, tumor or lesion;
    - surgical stent; or
    - surgical procedures for isolation of a tooth with rubber dam.

- **Temporomandibular Joint (TMJ) Disorder Treatment**
  - Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.

- **Tooth Transplantation**
  - Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

- **Veneers**

PEDIATRIC VISION

Pediatric Vision Services are covered for pediatric members as defined by the ACA. Covered Services are those services required for the diagnosis or correction of visual acuity and must be rendered by a Physician or optometrist practicing within the scope of their license.

Pediatric Vision Examination

One routine vision examination per Member per Calendar Year is covered, including dilation and with refraction.

Pediatric Vision Hardware

Hardware including frames, contacts (in lieu of glasses) and all lenses and tints are covered. Frames are covered to a maximum of one frame per Member per Calendar Year. Spectacle lenses are covered to a maximum of one pair per Member per Calendar Year, including polycarbonate lenses and scratch resistant coating. Low vision optical devices, aids, low vision services including comprehensive low vision evaluations and follow-up care are covered. Also covered are high power spectacles, magnifiers and telescopes. Two pairs of glasses may not be ordered in lieu of bifocals. Separate charges for

fittings will not be covered under the Contract.

PRESCRIPTION MEDICATIONS

Covered Prescription Medications

Benefits under this Prescription Medications provision are available for the following:

- At least one drug in every United States Pharmacopeia (USP) category and class;
- Diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Therapeutic continuous glucose monitors and insulin pumps, and their supplies, that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order; therapeutic continuous glucose monitors and insulin pumps, and their supplies
- Prescription Medications;
- Emergency Fill five-day supply or the minimum packaging size available at the time the Emergency Fill is dispensed;
- Foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States, except as may be provided under the Investigational definition in the Definitions Section of this Contract;
- Certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- Medications intended to treat opioid overdose may include but are not limited to;
- All FDA-approved contraception methods;
- Immunizations for adults and children according to, and as recommended by, the CDC;
- Specialty Medications;
- Therapeutic injections and related supplies when given in a professional Provider's office;
- Self-Administrable Cancer Chemotherapy Medication;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications);
- Growth hormones (if preauthorized); and.
- Medications dispensed while an inpatient in a Hospital, Skilled Nursing Facility, or mental health or substance use disorder inpatient or residential treatment facility or other facility, that is not a Participating Pharmacy, will be provided under the applicable benefit.
- If an equivalent Generic Medication is available and You choose to fill a Prescription Order with a Brand- Name Medication, even if the prescribing Provider specifies that the Brand-Name Medication must be dispensed, You will be responsible for paying the difference in cost (which does not count toward Your Deductible or Out-of-Pocket Maximum). The difference is calculated at the time of purchase based upon the difference in price between the equivalent Generic Medication and the applicable Brand-Name Medication, in addition to the Copayment and/or Coinsurance (as applicable). You will not be responsible for the difference in cost if Your Brand-Name Medication has been preauthorized or an exception has been granted through the prescription drug utilization management exception process.

Limitations

The following limitations apply to this Prescription Medications benefit, except for certain preventive medications as specified in the Covered Prescription Medications section:

Prescription Medication Supply Limits

- 30-Day Supply Limit:
  - **Specialty Medications** – the largest allowable quantity for a Specialty Medication is a 30-day supply. The first fill is allowed at a Pharmacy. Additional fills must be purchased from a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. Specialty medications are not allowed through Home Delivery Suppliers.
- 90-Day Supply Limit:
  - **Participating Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Participating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Home Delivery Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Multiple-Month Supply** – the maximum number of days for a covered Prescription Medication that is packaged in a multiple-month supply and is purchased from a Participating Pharmacy is a 90-day supply (even if the manufacturer packaging includes a larger supply).

Exclusions

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medications benefit:

- Biological Sera, Blood or Blood Plasma
- Brand-Name Medications not on the Formulary, preauthorized or Provided Through the prescription drug utilization management exception process
- Cosmetic Purposes: Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin, Exclusion for medically necessary treatments of a covered benefit does not apply.
- Foreign Prescription Medications: Foreign Prescription Medications for non-Emergency Medical Conditions while traveling outside the United States are not covered.
- Non-Self-Administrable Medications
- Nonprescription Medications: Medications that by law do not require a Prescription Order and which are not included in the definition of Prescription Medications, shown below, and are not included in the formulary, unless the medication is a contraceptive.
- Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

  Prescription Medications Not Dispensed by a Participating Pharmacy
- Prescription Medications Not within a Provider's License: Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
- Prescription Medications without Examination: Coverage excludes prescriptions made by a Provider without recent and relevant in-person (or Telemedicine) examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.
- Professional Charges for Administration of Any Medication
- Travel Immunizations Received for Purposes of Travel, Occupation or Residence in a Foreign

Country

PROSTHETIC DEVICES
Prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, mastectomy bras, external or internal breast prostheses are covered when deemed medically necessary by a licensed provider. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital inpatient care or Hospital outpatient and Ambulatory Service Facility care). Repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

RECONSTRUCTIVE SERVICES AND SUPPLIES
Inpatient and outpatient services for treatment of reconstructive services and supplies are covered:

- to treat 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, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice of this Contract.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

REHABILITATION SERVICES
Inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness as specified on the Schedule of Benefits are covered. Inpatient services are limited to a maximum of 30 days per Member per Calendar Year. Outpatient services are limited to a maximum of 25 visits per Member per Calendar Year. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

SKILLED NURSING FACILITY (SNF) CARE
The inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability to a maximum of 60 inpatient days per Member per Calendar Year are covered. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary.

SPINAL MANIPULATIONS
Spinal manipulations performed by any Provider to a maximum of ten spinal manipulations per Member per Calendar Year are covered. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits.

SUBSTANCE USE DISORDER SERVICES
Substance Use Disorder Services for treatment of Substance Use Disorder Conditions are covered, including the following:

- acupuncture services as medically necessary; and
- Prescription Medications that are prescribed and dispensed through a substance use disorder treatment facility (such as methadone).

Definitions
The following definitions apply to this Substance Use Disorder Services benefit:

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention

and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs, however services by Physicians or Practitioners in such settings may be covered if they are billed independently and otherwise would be covered.

Substance Use Disorder Conditions means substance use disorders included in the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association,

Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is determined by Us to be Medically Necessary),

For the Substance Use Disorder Services benefit, "medically necessary" or "medical necessity" is defined by the American Society of Addiction Medicine patient placement criteria. Patient placement criteria means the admission, continued service and discharge criteria set forth in the most recent version of the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

TELEMEDICINE

The plan covers telemedicine (audio and video communication) services between a Physician, the patient and a consulting Practitioner.

A health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

- The plan provides coverage of the health care service when provided in person by the provider;
- The health care service is medically necessary;
- The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015;
- The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and
- for audio-only telemedicine, the covered person has an established relationship with the provider.

An originating site for a telemedicine health care service includes a:

- Hospital;
- Rural health clinic;
- Federally qualified health center;
- Physician's or other health care provider's office;
- Licensed or certified behavioral health agency;
- Skilled nursing facility;
- Home or any location determined by the individual receiving the service; or
- Renal dialysis center, except an independent renal dialysis center.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS
Inpatient and outpatient services for treatment of temporomandibular joint (TMJ) disorders may be covered if deemed medically necessary by a licensed physician.

"Covered services" for the purpose of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not Investigational or primarily for Cosmetic purposes.

TRANSPLANTS
Transplants, including transplant-related services and supplies for covered transplants are covered. A transplant recipient who is covered under this plan and fulfills Medically Necessary criteria will be eligible for the following transplants, including any artificial organ transplants based on medical guidelines and manufacturer recommendations: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions).

Donor Organ Benefits
Donor organ procurement costs if the recipient is covered for the transplant under this plan are covered. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs.

URGENT CARE CENTER
Office visits for treatment of Illness or Injury are covered. All other professional services not billed as an office visit, or that are not related to the actual visit (separate facility fees billed in conjunction with the office visit for example) are not considered an office visit under this provision. Outpatient services and supplies (not billed as an office visit) provided by an Urgent Care Center are also covered.

III. Conditions of Coverage

MEDICAL NECESSITY
Health plans may limit coverage to services that are medically necessary for treatment of a covered person’s condition.

UTILIZATION MANAGEMENT
Health plans may apply utilization management such as prior authorization and step therapy in accordance with applicable state and federal regulations.

IV. General Exclusions

The following are the general exclusions from coverage under the Contract. Other exclusions may apply and, if so, will be described elsewhere.

SPECIFIC EXCLUSIONS
Benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them** will not be provided.

However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury; or 2) a preventive service as specified under the Preventive Care and Immunizations and Prescription Medications benefits.

Conditions Caused By Active Participation In a War or Insurrection
The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic Services and Supplies
Cosmetic services and supplies. Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance. Exclusion for medically necessary treatments of a covered benefit does not apply

Counseling in the Absence of Illness
Counseling in the absence of a physical, mental health or substance use disorder condition is not covered. Examples of services not covered under this exclusion are as follows: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program ("EAP") services; wilderness programs; premarital or marital counseling; and family counseling when the identified patient is not a child or an adolescent with a covered diagnosis and family counseling is not part of the treatment.

Custodial Care
Non-skilled care and helping with activities of daily living.

Dental Services for Adults
Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth for adults as defined by the ACA are not covered.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. Excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law are not covered.

Investigational Services
Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Coverage excludes any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section.

Motor Vehicle No-Fault Coverage
Expenses for services and supplies that have been covered or have been accepted for coverage under any automobile medical personal injury protection ("PIP") no-fault coverage. If Your expenses for services and supplies have been covered or have been accepted for coverage by an automobile medical personal injury protection ("PIP") carrier, coverage is provided for benefits according to the

Contract once Your claims are no longer covered by that carrier.

Non-Direct Patient Care
Services that are not direct patient care, including:

- appointments scheduled and not kept ("missed appointments");
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms; and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Obesity or Weight Reduction/Control
Medical treatment, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction are not covered, except where coverage is required by federal law or is a designated preventive service under federal or state law.

Orthognathic Surgery
Services and supplies for orthognathic surgery **not** required due to temporomandibular joint disorder, Injury, sleep apnea or congenital anomaly. "Orthognathic surgery," refers to surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes are not covered.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Member's Provider.

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Member's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Member arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-medical self-care, training programs, including:

- diet and weight monitoring services;
- childbirth-related classes including infant care and breast-feeding classes; and
- instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a Member of Your immediate family. For purposes of this provision, "immediate family" means parents, spouse, children, siblings, half-siblings, parent-in-law, child- in-law, sibling-in-law, half-sibling-in-law, or any relative by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary or Dentally Appropriate
Services and supplies that are not Dentally Appropriate for treatment or prevention of diseases or conditions of the teeth or Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
Non-mental health services and supplies for or in connection with sexual dysfunction regardless of cause are not covered.

Third Party Liability
Services and supplies for treatment of Illness or Injury for which a third party is responsible.

Travel and Transportation Expenses
Travel and transportation expenses when the purpose of the transportation is for personal or convenience purposes.

Vision Care
Routine eye exam and vision hardware for adults as defined by the ACA.

Visual therapy, training and eye exercises, vision orthoptics, prism lenses, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Member may be required to file a claim for workers' compensation benefits before providing any benefits under the Contract. The only exception is if an Enrolled Employee is exempt from state or federal workers' compensation law. If the entity providing workers' compensation coverage denies Your claims and You have filed an Appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Third-Party Liability provision.

V. Definitions

The following are definitions of important terms used in this document. Other terms are defined where they are first used.

Ambulatory Service Facility means a facility, licensed by the state in which it is located, that is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Member's Effective Date.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections of the Contract.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Emergency Medical Condition means a medical, mental health or substance use disorder condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent

layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Member's health, or with respect to a pregnant Member, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

Enrolled Employee means an employee of the Group who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage.

Essential Benefits are determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include at least the following general categories and the items and services covered within the categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

Family means an Enrolled Employee and his or her Enrolled Dependents.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Investigational means a Health Intervention that is have classified as Investigational. Scientific Evidence from well-designed clinical studies found in Peer-Reviewed Medical Literature will be reviewed, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria, is Investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for

the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-Reviewed Medical Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:

- Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
- Standard Reference Compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider, and not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

Medical necessity determinations are made by health professionals applying their training and experience, and using applicable medical policies developed through periodic review of generally accepted standards of medical practice.

Member means an Enrolled Employee or an Enrolled Dependent.

Physician means an individual who is duly licensed as a doctor of medicine (M.D.), doctor of osteopathy (D.O.) or doctor of naturopathic medicine (N.D.) who is a Provider covered under the Contract.

Placement for Adoption means an assumption of a legal obligation for total or partial support of a child in anticipation of adoption of the child. Upon termination of all legal obligation for support, placement ends.

Practitioner means an individual who is duly licensed to provide medical, surgical or behavioral health services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists

(doctor of medical dentistry or doctor of dental surgery, or a denturist) and other professionals practicing within the scope of their respective licenses.

Primary Provider means a Physician or Practitioner who is a general or family practitioner; an internist; a pediatrician or an obstetrical/gynecologist (Ob/Gyn) who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed.

Provider means a Hospital, Skilled Nursing Facility, ambulatory services facility, Physician, Practitioner or other individual or organization which is duly licensed to provide medical, surgical or behavioral health services.

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Specialist means a Physician or Practitioner that does not otherwise meet the definition of a Primary Provider or Practitioner.

Appendix
A. Washington State Mandates

Benefit Description	Citation
Hospice services	Revised Code of Washington 48.21.220 Revised Code of Washington 48.44.320
Home health care services	Revised Code of Washington 48.21.220 Revised Code of Washington 48.44.320
Emergency medical services in an emergency department to screen and stabilize	Revised Code of Washington 48.43.093
Congenital anomalies in children and newborns	Revised Code of Washington 48.20.430 Revised Code of Washington 48.21.155 Revised Code of Washington 48.44.212 Revised Code of Washington 48.46.250
Newborn length of stay equivalent to mother's, not less than 3 weeks	Revised Code of Washington 48.43.115
Maternity services and prescription drug coverage for maternity services	Revised Code of Washington 48.43.041(1)(a)
Mental health services, including prescription drugs to treat	Revised Code of Washington 48.20.580 Revised Code of Washington 48.21.241 Revised Code of Washington 48.44.341 Revised Code of Washington 48.46.291
Mental health parity	Revised Code of Washington 48.20.580 Revised Code of Washington 48.21.241 Revised Code of Washington 48.44.341 Revised Code of Washington 48.46.291
Chemical dependency treatment	Revised Code of Washington 48.21.180 Revised Code of Washington 48.44.240 Revised Code of Washington 48.46.350
Chemical dependency treatment	Revised Code of Washington 48.21.180 Revised Code of Washington 48.44.240 Revised Code of Washington 48.46.350
Neurodevelopmental therapy – speech, occupational, and physical therapy	Revised Code of Washington 48.21.310 Revised Code of Washington 48.44.450 Revised Code of Washington 48.46.520
Colorectal cancer screening and examinations	Revised Code of Washington 48.43.043
Mammogram diagnostic and screening	Revised Code of Washington 48.20.393 Revised Code of Washington 48.21.225 Revised Code of Washington 48.44.325 Revised Code of Washington 48.46.275
Prostate cancer screening	Revised Code of Washington 48.20.392 Revised Code of Washington 48.21.227 Revised Code of Washington 48.44.327 Revised Code of Washington 48.46.277

Benefit Description	Citation
Rehabilitative speech therapy	Revised Code of Washington 48.21.310 Revised Code of Washington 48.44.450 Revised Code of Washington 48.46.520
Rehabilitative occupational and rehabilitative physical therapy	Revised Code of Washington 48.21.310 Revised Code of Washington 48.44.450 Revised Code of Washington 48.46.520
Treatment for temporomandibular joint disorders	Revised Code of Washington 48.21.320 Revised Code of Washington 48.44.460 Revised Code of Washington 48.46.530
Reconstructive breast surgery resulting from a mastectomy due to disease, illness or injury	Revised Code of Washington 48.20.395 Revised Code of Washington 48.21.230 Revised Code of Washington 48.44.330 Revised Code of Washington 48.46.280
Diabetes coverage; equipment and supplies, training, education and medical nutrition	Revised Code of Washington 48.20.391 Revised Code of Washington 48.21.143 Revised Code of Washington 48.44.315 Revised Code of Washington 48.46.272
Medical foods for inborn metabolic disorder, including Phenylketonuria (PKU)	Revised Code of Washington 48.20.520 Revised Code of Washington 48.21.300 Revised Code of Washington 48.44.440 Revised Code of Washington 48.46.510
Anesthesia for dental services to those under age 7, or whose medical condition requires dental anesthesia, including facility charges	Revised Code of Washington 48.43.185

B. Summary Benefits

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	Yes	14	Day(s) per Lifetime		
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Covered	No			Only artificial insemination is covered.	Artificial Insemination must be covered as it is covered by the state base benchmark plan.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	No	Not Covered	No				
Routine Eye Exam (Adult)	No	Not Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year		
Emergency Room Services	Yes	Covered	No				
Emergency Transportation/Ambulance	Yes	Covered	No				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	No	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				Covers cosmetic surgery when medically necessary.
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year		Coverage is limited to 60-inpatient days/year.
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				
Generic Drugs	Yes	Covered	No	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.
Preferred Brand Drugs	Yes	Covered	No	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.
Non-Preferred Brand Drugs	Yes	Covered	No	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.
Specialty Drugs	Yes	Covered	No	30	Days per Month		First fill allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy. Coverage is limited to a 30-day supply for specialty and self- administrable cancer chemotherapy

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
							medications from a specialty pharmacy per fill or refill.
Outpatient Rehabilitation Services	Yes	Covered	Yes	25	Visit(s) per Year		
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Year		Coverage for habilitative services is limited to 30-inpatient days/year. Coverage for habilitative services is limited to 25-outpatient visits/year.
Chiropractic Care	Yes	Covered	Yes	10	Visits(s) per Year		
Durable Medical Equipment	Yes	Covered	No				
Hearing Aids	Yes	Covered	No	1 per Ear	Item(s) per 3 Years	An annual hearing exam and one hearing aid per ear each 3 years is covered. Cochlear Implants for children are also covered.	Coverage is limited to an annual hearing exam and one hearing aid per ear every 3 years. Cochlear Implants for children are also covered.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	Yes	Covered	No				
Acupuncture	Yes	Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Year		
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Year		Coverage is limited to one frame and one pair (two lenses) / calendar year or contacts (in lieu of glasses).
Dental Check-Up for Children	Yes	Covered	Yes	2	Visit(s) per Year		
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Year		Coverage is limited to 30-inpatient days/year and 25-outpatient visits/year. Rehabilitative Speech Therapy and Rehabilitative Occupational and Rehabilitative Physical Therapy combine for 25 visits

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
							for Rehabilitative Services and 25 visits for Habilitative Services.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Year		Coverage is limited to 30-inpatient days/year and 25-outpatient visits/year. Rehabilitative Speech Therapy and Rehabilitative Occupational and Rehabilitative Physical Therapy combine for 25 visits for Rehabilitative Services and 25 visits for Habilitative Services.
Well Baby Visits and Care	Yes	Covered	No			Human donor milk is covered in an inpatient setting when applicable criteria is met as outlined in RCW 48.43.815. See	Human donor milk must be covered as it is covered by the state base benchmark plan.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
						EHB base benchmark plan for details.	
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	Yes	1	Exam(s) per Year		
Orthodontia - Child	Yes	Covered	No			Orthodontia that is not medically necessary.	Medically necessary orthodontia must be covered.
Major Dental Care - Child	Yes	Covered	No			Exclusions apply - see EHB base benchmark plan.	Quantitative limits apply; see EHB base benchmark plan.
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No				Coverage includes termination of pregnancy for all female members.
Transplant	Yes	Covered	No				
Accidental Dental	No	Not Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Dialysis	Yes	Covered	No				
Allergy Testing	No	Not Covered	No				
Chemotherapy	Yes	Covered	No			Coverage of oral anti-cancer drugs is limited to a 30-day supply for specialty and self-administrable cancer chemotherapy medications from a specialty pharmacy; other chemotherapy is covered under the applicable service (such as office visit).	Covered under the base benchmark plan.
Radiation	Yes	Covered	No				Covered under the base benchmark plan; covered under applicable benefit (such as office visit).
Diabetes Education	Yes	Covered	No				
Prosthetic Devices	Yes	Covered	No				
Infusion Therapy	Yes	Covered	No				Covered under applicable benefit (such as office visit).
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Nutritional Counseling	Yes	Covered	No				
Reconstructive Surgery	Yes	Covered	No				Coverage for reconstructive breast surgery and treatment of congenital anomalies is required and is covered under the state-based benchmark plan.
Gender Affirming Care	Yes	Covered	No				Gender Affirming Care includes health care services prescribed to treat any condition related to the individual's gender identity and may include primary care visits, specialty care, outpatient mental health services, prescription drug benefits, and surgical services.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Diabetes Care Management	Yes	Covered	No				
Inherited Metabolic Disorder – PKU	Yes	Covered	No				
Dental Anesthesia	Yes	Covered	No				