\blacksquare	A B	C	D	E	F	G	Н	I	J	K	L M dividual Market	N	0	Р	Q	R	S	Ţ	U
2		П							T .	ın	dividual Market	П		1					1
3	Required Cha	anges		Opt	ional Change	es (see instruction	is)												
4						After Add-In File (7.2) Undate									201	8 Plan Year		
6	Benefit Information						General Information				Benefit Information							neral Information	
	Benefits	ЕНВ	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason		Benefits		Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
7 Pr	mary Care Visit to Treat an Injury or	Yes	Covered	OII OLIVICO					Ittuson		Primary Care Visit to Treat an Injury or		Covered	OH GETTICE					reason
8	Illness Specialist Visit	Yes	Covered								Illness Specialist Visit	Yes	Covered						
	her Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered								Other Practitioner Office Visit (Nurse,	Yes	Covered						
10 Out	Physician Assistant) patient Facility Fee (e.g., Ambulatory	Yes	Covered								Physician Assistant) Outpatient Facility Fee (e.g., Ambulatory		Covered						
11	Surgery Center)	Yes	Covered								Surgery Center)	Yes	Covered						
12	tpatient Surgery Physician/Surgical Services	Yes	Covered								Outpatient Surgery Physician/Surgical Services	Yes	Covered						
13 14	Hospice Services Routine Dental Services (Adult)	Yes	Covered	Yes	14	Days per Lifetime					Hospice Services Routine Dental Services (Adult)	Yes	Covered	Yes	14	Days per Lifetime			
15	Infertility Treatment										Infertility Treatment								
16	ong-Term/Custodial Nursing Home Care										Long-Term/Custodial Nursing Home Care								
17	Private-Duty Nursing Routine Eye Exam (Adult)										Private-Duty Nursing Routine Eye Exam (Adult)								
19	Urgent Care Centers or Facilities	Yes	Covered								Urgent Care Centers or Facilities	Yes	Covered						
20	Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year					Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year			
21	Emergency Room Services ergency Transportation/Ambulance	Yes Yes	Covered								Emergency Room Services Emergency Transportation/Ambulance	Yes Yes	Covered						
22	Innatiant Moenital Services (e.g.										Innations Magnital Pagaines (s. s.								
23	Hospital Stay)	Yes	Covered								Hospital Stay)	Yes	Covered						
24 25	Inpatient Physician and Surgical Services Bariatric Surgery	Yes	Covered								Services Bariatric Surgery	Yes	Covered						
26	Cosmetic Surgery										Cosmetic Surgery								
27 28	Skilled Nursing Facility Prenatal and Postnatal Care	Yes Yes	Covered Covered	Yes	60	Days per Year		Coverage is limited to 60-inpatient days/year.	<u> </u>		Skilled Nursing Facility Prenatal and Postnatal Care	Yes Yes	Covered Covered	Yes	60	Days per Year		Coverage is limited to 60-inpatient days/year.	
70 De	livery and All Inpatient Services for Maternity Care	Yes	Covered								Delivery and All Inpatient Services for Maternity Care	Yes	Covered						
N N	ental/Behavioral Health Outpatient	Yes	Covered								Mental/Behavioral Health Outpatient	Yes	Covered						
30	Services Mental/Behavioral Health Inpatient										Services Mental/Behavioral Health Inpatient	V-							
31	Services bstance Abuse Disorder Outpatient	Yes	Covered								Services Substance Abuse Disorder Outpatient	Yes	Covered						
32	Services	Yes	Covered								Services	Yes	Covered						
33 33	ubstance Abuse Disorder Inpatient Services	Yes	Covered								Substance Abuse Disorder Inpatient Services	Yes	Covered						
24	Generic Drugs	Yes	Covered				Coverage is lin	nited to a 30-day supply retail or 90-day supply mail order.			Generic Drugs	Yes	Covered	Yes	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.	Other Law/Regulation
-	Preferred Brand Drugs	Yes	Covered				Coverage is lin	nited to a 30-day supply retail or 90-day supply mail order.			Preferred Brand Drugs	Yes	Covered	Yes	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.	Other
35	Non-Preferred Brand Drugs	Yes	Covered								Non-Preferred Brand Drugs	Yes	Covered	Yes	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.	Caw/Regulation Other
36		165	Covered									163	COFCICU	165	30	Days per month			Law/Regulation
	Specialty Drugs	Yes	Covered				First fill allowed at a pharmacy. Coverage	retail pharmacy. Additional fills must be provided at a specialty is limited to a 30-day supply for specialty and self-administrable			Specialty Drugs	Yes	Covered	Yes	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	Other Law/Regulation
37							cancer cl	emotherapy medications from a specialty pharmacy.										medications from a specialty pharmacy per fill or refill.	Law/ Kegulation
38	Outpatient Rehabilitation Services	Yes	Covered	Yes	25	Visit(s) per Year					Outpatient Rehabilitation Services	Yes	Covered	Yes	25	Visit(s) per Year			
39	Habilitation Services	Yes	Covered	Yes	25	Visit(s) per Year	Coverage for habilith	ative services is limited to 30-inpatient days/year. Coverage for tive services is limited to 25-outpatient visits/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.	Other Law/Regulation
40	Chiropractic Care Durable Medical Equipment	Yes Yes	Covered Covered	Yes	10	Visit(s) per Year					Chiropractic Care Durable Medical Equipment	Yes Yes	Covered Covered	Yes	10	Visit(s) per Year			
-	Hearing Aids	Yes	Covered				Cochlear Impla	nts must be covered as they are covered by the state base			Hearing Aids	Yes	Covered					Cochlear Implants must be covered as they are covered by the state base benchmark plan.	
43		Yes	Covered					benchmark plan.			Imaging (CT/PET Scans, MRIs)	Yes	Covered						
Pre 44	rentive Care/Screening/Immunization	Yes	Covered								Preventive Care/Screening/Immunization	Yes	Covered						
45	Routine Foot Care Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year					Routine Foot Care Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year			
47	Weight Loss Programs	165	Covered	165	12	Visitisi Dei Teal					Weight Loss Programs	165	Covered	165	12	VISION DEL TEGI			
48	Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Year					Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Year			
49	Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Year	Coverage is limited t	o one frame and one pair (two lenses)/ calendar year or contacts (in lieu of glasses).			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).	
50	Dental Check-Up for Children	Yes	Covered	Yes	2	Visit(s) per Year					Dental Check-Up for Children	Yes	Covered	Yes	2	Visit(s) per Year			
П							Coverage is lim	ited to 30-inpatient days/year and 25-outpatient visits/year.										Coverage is limited to 30-inpatient days/year and 25-outpatient visits/year. Rehabilitative Speech	
	Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Year	Physical Therapy of	ch Therapy and Rehabilitative Occupational and Rehabilitative ombine for 25 visits for Rehabilitative Services and 25 visits for			Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Year		Therapy and Rehabilitative Occupational and Rehabilitative Physical Therapy combine for 25 visits for Rehabilitative Services and 25 visits for Habilitative Services.	
31		+					Coverage is lim	Habilitative Services. ited to 30-inpatient days/year and 25-outpatient visits/year.										Coverage is limited to 30-inpatient days/year and 25-outpatient visits/year. Rehabilitative Speech	
	Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Year	Rehabilitative Spec	ch Therapy and Rehabilitative Occupational and Rehabilitative ombine for 25 visits for Rehabilitative Services and 25 visits for			Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Year		Therapy and Rehabilitative Occupational and Rehabilitative Physical Therapy combine for 25 visits for Rehabilitative Services and 25 visits for Habilitative Services.	
52	Well Baby Visits and Care	Yes	Covered					Habilitative Services.			Well Baby Visits and Care	Yes	Covered					Nonaumanye Serwes and 23 VISIIS IOF FAUIRIARYE SERVICES.	
Lal	oratory Outpatient and Professional Services	Yes	Covered								Laboratory Outpatient and Professional Services	Yes	Covered						
55	X-rays and Diagnostic Imaging	Yes	Covered									Yes	Covered						
56	Basic Dental Care - Child	Yes	Covered	Yes	1	Exam(s) per Year					Basic Dental Care - Child	Yes	Covered	Yes	1	Exam(s) per Year			
57 58	Orthodontia – Child Major Dental Care – Child	Yes Yes	Covered Covered				Me Quant	dically necessary orthodontia must be covered. tative limits apply; see EHB base benchmark plan.			Major Dental Care - Child	Yes Yes	Covered Covered					Medically necessary orthodontia must be covered. Quantitative limits apply; see EHB base benchmark plan.	
58 59 60	Basic Dental Care - Adult						Quant	app. 11 and a state of the stat			Basic Dental Care - Adult							and any of the state of the sta	
61	Orthodontia – Adult Major Dental Care – Adult										Orthodontia – Adult Major Dental Care – Adult								
62 62	portion for Which Public Funding is Prohibited	ᆫ									Abortion for Which Public Funding is Prohibited								
63	Transplant Accidental Dental	Yes	Covered								Transplant Accidental Dental	Yes	Covered						
65	Dialysis	Yes	Covered								Dialysis	Yes	Covered						
65 66 67	Allergy Testing Chemotherapy	Yes	Covered					Covered under the base benchmark plan.			Allergy Testing Chemotherapy	Yes	Covered					Covered under the base benchmark plan.	
68	Radiation	Yes	Covered				Covered under the b	ase benchmark plan; covered under applicable benefit (such as office visit).			Radiation	Yes	Covered			·		Covered under the base benchmark plan; covered under applicable benefit (such as office visit).	
68 69 70 71		Yes	Covered									Yes							
71	Infusion Therapy	Yes Yes	Covered Covered				Cove	red under applicable benefit (such as office visit).			Infusion Therapy	Yes Yes	Covered Covered					Covered under applicable benefit (such as office visit).	
Tre	atment for Temporomandibular Joint Disorders	Yes	Covered								Treatment for Temporomandibular Joint Disorders	Yes	Covered						
72		Yes	Covered									Yes	Covered						
П	Reconstructive Surgery	Yes	Covered				This coverage is re	quired under the following laws: RCW 48.20.395, 48.20.430, 0, 48.44.212, 48.44.330, 48.46.250, 48.46.280, WAC 284-43-			Reconstructive Surgery	Yes	Covered					Coverage for reconstructive breast surgery and treatment of congenital anomalies is required and is	
74		100	Covered				40.21.103, 48.21.2	878(3)(b)(ii), and WAC 284-50-320(6)(e).				100						covered under the state base benchmark plan.	Additionation
75											Diabetes Care Management		Covered						Benefit
76		┖╻╻		<u></u>	<u> </u>						Inherited Metabolic Disorder - PKU		Covered	L			<u></u>		Additional EHB Benefit
77											Dental Anesthesia		Covered						Benefit Additional EHB
77						1	1												Benefit

A B	С	D	E	F	G	Н	I	J	К	L М mall Group Market	N	0	P	Q	R	S	Ţ	U
1									5	mall Group Market								
3 Required Cha	anges		Option	nal Changes ((see instructions)													
5					After Add-In Fil	e (7.2) Update									2018 Plan Y	ear		
6 Benefit Information		Is this Renefit	Quantitative Limit on	Limit			nformation	EHB Variance		Benefit Information			Quantitative Limit on	Limit		General Info		
7 Benefits Primary Care Visit to Treat an Injury or	EHB Yes	Covered? Covered	Service	Quantity	Limit Unit	Exclusions	Benefit Explanation	Reason		Benefits Primary Care Visit to Treat an Injury or	EHB Yes	Is this Benefit Covered?	Service	Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
8 Illness 9 Specialist Visit	Yes	Covered								Illness Specialist Visit	Yes	Covered						
Other Practitioner Office Visit (Nurse, 10 Physician Assistant)	Yes	Covered								Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered						
Outpatient Facility Fee (e.g., 11 Ambulatory Surgery Center)	Yes	Covered								Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered						
Outpatient Surgery Physician/Surgical Services	Yes	Covered								Outpatient Surgery Physician/Surgical Services	Yes	Covered						
13 Hospice Services 14 Routine Dental Services (Adult) 15 Infertility Treatment	Yes	Covered	Yes	14	Days per Lifetime					Hospice Services Routine Dental Services (Adult)	Yes	Covered	Yes	14	Days per Lifetime			
15 Infertility Treatment Long-Term/Custodial Nursing Home										Infertility Treatment								
16 Care										Long-Term/Custodial Nursing Home Care								
17 Private-Duty Nursing 18 Routine Eye Exam (Adult) 19 Urgent Care Centers or Facilities 20 Home Health Care Services										Private-Duty Nursing Routine Eye Exam (Adult)								
19 Urgent Care Centers or Facilities 20 Home Health Care Services	Yes Yes	Covered Covered	Yes	130	Visit(s) per Year					Urgent Care Centers or Facilities Home Health Care Services	Yes Yes	Covered Covered	Yes	130	Visit(s) per Year			
21 Emergency Room Services	Yes	Covered								Emergency Room Services	Yes	Covered						
Emergency Transportation/Ambulance Inpatient Hospital Services (e.g., Hospital	Yes	Covered								Emergency Transportation/Ambulance Inpatient Hospital Services (e.g.,	Yes	Covered						
23 Stay)	Yes	Covered								Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered						
24 Inpatient Physician and Surgical Services 25 Bariatric Surgery	Yes	Covered								Inpatient Physician and Surgical Services Bariatric Surgery	Yes	Covered						
25 Bariatric Surgery 26 Cosmetic Surgery 27 Skilled Nursing Facility	Yes	Covered	Yes	en	Down see Vee		Courses is limited to 60 innetient developer			Cosmetic Surgery	Vo-	Coursed	V	60	Daws new Vees		Countries is limited to 60 inputions developer	
28 Prenatal and Postnatal Care	Yes	Covered Covered	168	6U	Days per Year		Coverage is limited to 60-inpatient days/year.			Skilled Nursing Facility Prenatal and Postnatal Care	Yes Yes	Covered Covered	Yes	60	Days per Year		Coverage is limited to 60-inpatient days/year.	
Delivery and All Inpatient Services for 29 Maternity Care	Yes	Covered								Delivery and All Inpatient Services for Maternity Care	Yes	Covered						
Mental/Behavioral Health Outpatient 30 Services	Yes	Covered								Mental/Behavioral Health Outpatient Services	Yes	Covered						
Mental/Behavioral Health Inpatient 31 Services	Yes	Covered								Mental/Behavioral Health Inpatient Services	Yes	Covered						
Substance Abuse Disorder Outpatient 32 Services	Yes	Covered								Substance Abuse Disorder Outpatient Services	Yes	Covered						
Substance Abuse Disorder Inpatient 33 Services	Yes	Covered								Substance Abuse Disorder Inpatient Services	Yes	Covered						
Generic Drugs	Yes	Covered					Coverage is limited to a 30-day supply retail or 90-day supply mail order.			Generic Drugs	Yes	Covered	Yes	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.	Other Law/Regulation
Preferred Brand Drugs	Yes	Covered					Coverage is limited to a 30-day supply retail or 90-day supply mail order.			Preferred Brand Drugs	Yes	Covered	Yes	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.	Other Law/Regulation
Non-Preferred Brand Drugs	Yes	Covered								Non-Preferred Brand Drugs	Yes	Covered	Yes	30	Days per Month		Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill.	Other Law/Regulation
Canadalla Davas	V	C					First fill allowed at a retail pharmacy. Additional fills must be provided at a specialty sharmacy. Coverage is limited to a 30-day supply for specialty and self-administrable cancer			Panalaliu Duura	Yes	Cd	Ven		David and March		First fill allowed at a retail pharmacy. Additional fills must be provided at a specialty	Others Law (Deve Javier
Specialty Drugs 37	Yes	Covered					onarmacy. Coverage is limited to a 30-day supply for specialty and self-administracie cancer chemotherapy medications from a specialty pharmacy.			Specialty Drugs	Yes	Covered	Yes	30	Days per Month		pharmacy. Coverage is limited to a 30-day supply for specialty and self-administrable cancel chemotherapy medications from a specialty pharmacy per fill or refill.	Other Law/Regulation
Outpatient Rehabilitation Services	Yes	Covered	Yes	25	Visit(s) per Year					Outpatient Rehabilitation Services	Yes	Covered	Yes	25	Visit(s) per Year			
Habilitation Services	Yes	Covered	Yes	25	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.			Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Year		Coverage for habilitative services is limited to 30-inpatient days/year. Coverage for habilitativ services is limited to 25-outpatient visits/year.	Other Law/Regulation
40 Chiropractic Care 41 Durable Medical Equipment	Yes Yes	Covered	Yes	10	Visit(s) per Year		,			Chiropractic Care Durable Medical Equipment	Yes	Covered	Yes	10	Visit(s) per Year			
Hearing Aids	Yes	Covered					Cochlear Implants must be covered as they are covered by the state base benchmark plan.			Hearing Aids	Yes Yes	Covered Covered					Cochlear Implants must be covered as they are covered by the state base benchmark plan.	
42 43 Imaging (CT/PET Scans, MRIs)	Yes	Covered								Imaging (CT/PET Scans, MRIs)	Yes	Covered						
Preventive Care/Screening/Immunization	Yes	Covered								Preventive Care/Screening/Immunization	Yes	Covered						
45 Routine Foot Care 46 Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year					Routine Foot Care Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year			
47 Weight Loss Programs 48 Routine Eye Exam for Children	Yes	Covered	Yes							Weight Loss Programs Routine Eye Exam for Children				- 12				
Eye Glasses for Children	Yes	Covered	Yes	1	Exam(s) per Year Item(s) per Year		Coverage is limited to one frame and one pair (two lenses)/ calendar year or contacts (in lieu			Eye Glasses for Children	Yes	Covered	Yes	1	Exam(s) per Year Item(s) per Year		Coverage is limited to one frame and one pair (two lenses)/ calendar year or contacts (in lieu	
50 Dental Check-Up for Children	Yes	Covered	Yes	2	Visit(s) per Year	•	of glasses).			Dental Check-Up for Children	Yes	Covered	Yes	2	Visit(s) per Year		of glasses).	
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 for Rehabilitative Services and 25 visits for Habilitative Services.			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 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.			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.	
52 53 Well Baby Visits and Care	Yes	Covered								Well Baby Visits and Care	Yes	Covered					The state of the s	
Laboratory Outpatient and Professional 54 Services	Yes	Covered								Laboratory Outpatient and Professional Services	Yes	Covered						
55 X-rays and Diagnostic Imaging 56 Basic Dental Care – Child	Yes Yes	Covered Covered	Yes	1	Exam(s) per Year					X-rays and Diagnostic Imaging Basic Dental Care – Child	Yes Yes	Covered	Yes	1	Exam(s) per Year			
57 Orthodontia – Child 58 Major Dental Care – Child	Yes Yes	Covered Covered	. 25				Medically necessary orthodontia must be covered. Quantitative limits apply; see EHB base benchmark plan.			Orthodontia – Child Major Dental Care – Child	Yes Yes Yes	Covered	res		сланцо, рег теаг		Medically necessary orthodontia must be covered.	
59 Basic Dental Care – Child 60 Orthodontia – Adult	res	Covered					жилишто илио арру, эее стто изветентитак разг.			Basic Dental Care - Adult	165	Covered					Quantitative limits apply; see EHB base benchmark plan.	
61 Major Dental Care – Adult										Orthodontia – Adult Major Dental Care – Adult								
Abortion for Which Public Funding is 62 Prohibited										Abortion for Which Public Funding is Prohibited								
63 Transplant 64 Accidental Dental 65 Dialysis 66 Allergy Testing 67 Chemotherapy	Yes	Covered								Transplant Accidental Dental	Yes	Covered						
65 Dialysis 66 Allergy Testing	Yes	Covered								Dialysis Allergy Testing	Yes	Covered	1		·			
67 Chemotherapy							Covered under the base benchmark plan.			Chemotherapy	Yes	Covered					Covered under the base benchmark plan.	
Radiation 68	Yes	Covered					Covered under the base benchmark plan; covered under applicable benefit (such as office risit).			Radiation	Yes	Covered					Covered under the base benchmark plan; covered under applicable benefit (such as office visit).	
68 69 Diabetes Education 70 Prosthetic Devices 71 Infusion Therapy 72 Treatment for Temporomandibular Joint	Yes Yes	Covered								Diabetes Education Prosthetic Devices	Yes Yes	Covered Covered						
71 Infusion Therapy 72 Treatment for Temporomandibular Joint	Yes Yes	Covered Covered			 		Covered under applicable benefit (such as office visit).			Infusion Therapy Treatment for Temporomandibular Joint	Yes Yes	Covered Covered					Covered under applicable benefit (such as office visit).	
73 Nutritional Counseling	Yes	Covered					This coverage is required under the following laws: RCW 48.20.395, 48.20.430, 48.21.155,			Nutritional Counseling	Yes	Covered						
Reconstructive Surgery 74	Yes	Covered					this coverage is required under the following laws: RCW 48.20.395, 48.20.430, 48.21.155, 18.21.230, 48.44.212, 48.44.330, 48.46.250, 48.46.280, WAC 284-43-978(3)(b)(ii), and WAC 284-50-320(6)(e).			Reconstructive Surgery Diabetes Care Management	Yes	Covered					Coverage for reconstructive breast surgery and treatment of congenital anomalies is require and is covered under the state base benchmark plan.	Additional FHR Renefit
75										Inherited Metabolic Disorder - PKU		Covered						Additional EHB Benefit Additional EHB Benefit
76 77										Dental Anesthesia		Covered						Additional EHB Benefit

Washington State
Plans and Benefits Template Add-In Correction
Illustration

П	A		В	С	D	E	F	G	Н	I	J	К	L	М	N	0	Р	0	R	S	Ţ	U
1	Individual and Small Group Market Stand-Alone Pediatric Dental															•						
2	2																					
3	Stand	d-Alone Pedia	atric Denta	Require	ed Changes																	
4																						
5		After Add-In File (7.2) Update																201	18 Plan Year			
6	Ber	enefit Informa	tion						General Infori	nation			Benefit In	formation					Gene	ral Informati	on	
7		Benefits		ЕНВ	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason		Benefits		ЕНВ	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
8 F	Routine Dental Services (Adult)		lult)										Routine Dental Services (Adult)									
9 [ental Check	k-Up for Childre	n	Yes	Covered	Yes	2	Visit(s) per Year					Dental Check-Up for	Children	Yes	Covered	Yes	2	Visit(s) per Year			
10	asic Dental	I Care - Child		Yes	Covered	Yes	1	Exam(s) per Year				Basic Dental Care -	Child	Yes	Covered	Yes	1	Exam(s) per Year				
11	rthodontia -	- Child		Yes	Covered					Medically necessary orthodontia must be covered.			Orthodontia – Child		Yes	Covered					Medically necessary orthodontia must be covered.	
12	Major Dental Care – Child			Yes	Covered					Quantitative limits apply; see EHB base benchmark plan.	Quantitative limits apply; see EHB base benchmark plan.		Major Dental Care –		Yes	Covered					Quantitative limits apply; see EHB base benchmark plan.	
	3 Basic Dental Care - Adult									<u> </u>			Basic Dental Care -									
	Orthodontia – Adult												Orthodontia – Adult									
	15 Major Dental Care – Adult 16 Accidental Dental											Major Dental Care -	Adult									
16	ccidental De	Jentai											Accidental Dental									