Washington State
Plans and Benefits Template Add-In Correction
Illustration

Individual Market

Required Changes | **Optional Changes (see instructions)**

	After Add-In File (7.2) Update									2018 Plan Year									
	Benefit Information	*General Information*								*Benefit Information*	*General Information*								
	Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason	Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
8	Primary Care Visit to Treat an Injury or Illness	Yes	Covered							Primary Care Visit to Treat an Injury or Illness	Yes	Covered						
9	Specialist Visit	Yes	Covered							Specialist Visit	Yes	Covered						
10	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered							Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered						
11	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered							Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered						
12	Outpatient Surgery Physician/Surgical Services	Yes	Covered							Outpatient Surgery Physician/Surgical Services	Yes	Covered						
13	Hospice Services	Yes	Covered	Yes	14	Days per Lifetime				Hospice Services	Yes	Covered	Yes	14	Days per Lifetime			
14	Routine Dental Services (Adult)									Routine Dental Services (Adult)								
15	Infertility Treatment									Infertility Treatment								
16	Long-Term/Custodial Nursing Home Care									Long-Term/Custodial Nursing Home Care								
17	Private-Duty Nursing									Private-Duty Nursing								
18	Routine Eye Exam (Adult)									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	Yes	Covered							Emergency Room Services	Yes	Covered						
22	Emergency Transportation/Ambulance	Yes	Covered							Emergency Transportation/Ambulance	Yes	Covered						
23	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered							Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered						
24	Inpatient Physician and Surgical Services	Yes	Covered							Inpatient Physician and Surgical Services	Yes	Covered						
25	Bariatric Surgery									Bariatric Surgery								
26	Cosmetic Surgery									Cosmetic Surgery								
27	Skilled Nursing Facility	Yes	Covered	Yes	60	Days per Year		Coverage is limited to 60-inpatient days/year.		Skilled Nursing Facility	Yes	Covered	Yes	60	Days per Year		Coverage is limited to 60-inpatient days/year.	
28	Prenatal and Postnatal Care	Yes	Covered							Prenatal and Postnatal Care	Yes	Covered						
29	Delivery and All Inpatient Services for Maternity Care	Yes	Covered							Delivery and All Inpatient Services for Maternity Care	Yes	Covered						
30	Mental/Behavioral Health Outpatient Services	Yes	Covered							Mental/Behavioral Health Outpatient Services	Yes	Covered						
31	Mental/Behavioral Health Inpatient Services	Yes	Covered							Mental/Behavioral Health Inpatient Services	Yes	Covered						
32	Substance Abuse Disorder Outpatient Services	Yes	Covered							Substance Abuse Disorder Outpatient Services	Yes	Covered						
33	Substance Abuse Disorder Inpatient Services	Yes	Covered							Substance Abuse Disorder Inpatient Services	Yes	Covered						
34	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
35	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
36	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
37	Specialty Drugs	Yes	Covered					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 medications from a specialty pharmacy.		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 medications from a specialty pharmacy per fill or refill.	Other Law/Regulation
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 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 habilitative services is limited to 25-outpatient visits/year.	Other Law/Regulation
40	Chiropractic Care	Yes	Covered	Yes	10	Visit(s) per Year				Chiropractic Care	Yes	Covered	Yes	10	Visit(s) per Year			
41	Durable Medical Equipment	Yes	Covered							Durable Medical Equipment	Yes	Covered						
42	Hearing Aids	Yes	Covered					Cochlear Implants must be covered as they are covered by the state base benchmark plan.		Hearing Aids	Yes	Covered					Cochlear Implants must be covered as they are covered by the state base benchmark plan.	
43	Imaging (CT/PET Scans, MRIs)	Yes	Covered							Imaging (CT/PET Scans, MRIs)	Yes	Covered						
44	Preventive Care/Screening/Immunization	Yes	Covered							Preventive Care/Screening/Immunization	Yes	Covered						
45	Routine Foot Care									Routine Foot Care								
46	Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year				Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year			
47	Weight Loss Programs									Weight Loss Programs								
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 to 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			
51	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.	
52	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.	
53	Well Baby Visits and Care	Yes	Covered							Well Baby Visits and Care	Yes	Covered						
54	Laboratory Outpatient and Professional Services	Yes	Covered							Laboratory Outpatient and Professional Services	Yes	Covered						
55	X-rays and Diagnostic Imaging	Yes	Covered							X-rays and Diagnostic Imaging	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	Orthodontia – Child	Yes	Covered					Medically necessary orthodontia must be covered.		Orthodontia – Child	Yes	Covered					Medically necessary orthodontia must be covered.	
58	Major Dental Care – Child	Yes	Covered					Quantitative limits apply; see EHB base benchmark plan.		Major Dental Care – Child	Yes	Covered					Quantitative limits apply; see EHB base benchmark plan.	
59	Basic Dental Care – Adult									Basic Dental Care – Adult								
60	Orthodontia – Adult									Orthodontia – Adult								
61	Major Dental Care – Adult									Major Dental Care – Adult								
62	Abortion for Which Public Funding is Prohibited									Abortion for Which Public Funding is Prohibited								
63	Transplant	Yes	Covered							Transplant	Yes	Covered						
64	Accidental Dental									Accidental Dental								
65	Dialysis	Yes	Covered							Dialysis	Yes	Covered						
66	Allergy Testing									Allergy Testing								
67	Chemotherapy	Yes	Covered					Covered under the base benchmark plan.		Chemotherapy	Yes	Covered					Covered under the base benchmark plan.	
68	Radiation	Yes	Covered					Covered under the base 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).	
69	Diabetes Education	Yes	Covered							Diabetes Education	Yes	Covered						
70	Prosthetic Devices	Yes	Covered							Prosthetic Devices	Yes	Covered						
71	Infusion Therapy	Yes	Covered					Covered under applicable benefit (such as office visit).		Infusion Therapy	Yes	Covered					Covered under applicable benefit (such as office visit).	
72	Treatment for Temporomandibular Joint Disorders	Yes	Covered							Treatment for Temporomandibular Joint Disorders	Yes	Covered						
73	Nutritional Counseling	Yes	Covered							Nutritional Counseling	Yes	Covered						
74	Reconstructive Surgery	Yes	Covered					This coverage is required under the following laws: RCW 48.20.395, 48.20.430, 48.21.155, 48.21.230, 48.44.212, 48.44.330, 48.46.250, 48.46.280, WAC 284-43-878(3)(b)(ii), and WAC 284-50-320(6)(e).		Reconstructive Surgery	Yes	Covered					Coverage for reconstructive breast surgery and treatment of congenital anomalies is required and is covered under the state base benchmark plan.	
75										Diabetes Care Management		Covered						Additional EHB Benefit
76										Inherited Metabolic Disorder - PKU		Covered						Additional EHB Benefit
77										Dental Anesthesia		Covered						Additional EHB Benefit

Washington State
Plans and Benefits Template Add-In Correction
Illustration

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Small Group Market																				
2																					
3	Required Changes				Optional Changes (see instructions)																
4																					
5	After Add-In File (7.2) Update											2018 Plan Year									
6	Benefit Information		General Information									Benefit Information		General Information							
7	Benefits		EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason		Benefits		EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
8	Primary Care Visit to Treat an Injury or Illness		Yes	Covered								Primary Care Visit to Treat an Injury or Illness		Yes	Covered						
9	Specialist Visit		Yes	Covered								Specialist Visit		Yes	Covered						
10	Other Practitioner Office Visit (Nurse, Physician Assistant)		Yes	Covered								Other Practitioner Office Visit (Nurse, Physician Assistant)		Yes	Covered						
11	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	Covered								Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	Covered						
12	Outpatient Surgery Physician/Surgical Services		Yes	Covered								Outpatient Surgery Physician/Surgical Services		Yes	Covered						
13	Hospice Services		Yes	Covered	Yes	14	Days per Lifetime					Hospice Services		Yes	Covered	Yes	14	Days per Lifetime			
14	Routine Dental Services (Adult)											Routine Dental Services (Adult)									
15	Infertility Treatment											Infertility Treatment									
16	Long-Term/Custodial Nursing Home Care											Long-Term/Custodial Nursing Home Care									
17	Private-Duty Nursing											Private-Duty Nursing									
18	Routine Eye Exam (Adult)											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		Yes	Covered								Emergency Room Services		Yes	Covered						
22	Emergency Transportation/Ambulance		Yes	Covered								Emergency Transportation/Ambulance		Yes	Covered						
23	Inpatient Hospital Services (e.g., Hospital Stay)		Yes	Covered								Inpatient Hospital Services (e.g., Hospital Stay)		Yes	Covered						
24	Inpatient Physician and Surgical Services		Yes	Covered								Inpatient Physician and Surgical Services		Yes	Covered						
25	Bariatric Surgery											Bariatric Surgery									
26	Cosmetic Surgery											Cosmetic Surgery									
27	Skilled Nursing Facility		Yes	Covered	Yes	60	Days per Year		Coverage is limited to 60-inpatient days/year.			Skilled Nursing Facility		Yes	Covered	Yes	60	Days per Year		Coverage is limited to 60-inpatient days/year.	
28	Prenatal and Postnatal Care		Yes	Covered								Prenatal and Postnatal Care		Yes	Covered						
29	Delivery and All Inpatient Services for Maternity Care		Yes	Covered								Delivery and All Inpatient Services for Maternity Care		Yes	Covered						
30	Mental/Behavioral Health Outpatient Services		Yes	Covered								Mental/Behavioral Health Outpatient Services		Yes	Covered						
31	Mental/Behavioral Health Inpatient Services		Yes	Covered								Mental/Behavioral Health Inpatient Services		Yes	Covered						
32	Substance Abuse Disorder Outpatient Services		Yes	Covered								Substance Abuse Disorder Outpatient Services		Yes	Covered						
33	Substance Abuse Disorder Inpatient Services		Yes	Covered								Substance Abuse Disorder Inpatient Services		Yes	Covered						
34	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
35	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
36	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
37	Specialty Drugs		Yes	Covered					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 medications from a specialty pharmacy.			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 medications from a specialty pharmacy per fill or refill.	Other Law/Regulation
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 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 habilitative services is limited to 25-outpatient visits/year.	Other Law/Regulation
40	Chiropractic Care		Yes	Covered	Yes	10	Visit(s) per Year					Chiropractic Care		Yes	Covered	Yes	10	Visit(s) per Year			
41	Durable Medical Equipment		Yes	Covered								Durable Medical Equipment		Yes	Covered						
42	Hearing Aids		Yes	Covered					Cochlear Implants must be covered as they are covered by the state base benchmark plan.			Hearing Aids		Yes	Covered					Cochlear Implants must be covered as they are covered by the state base benchmark plan.	
43	Imaging (CT/PET Scans, MRIs)		Yes	Covered								Imaging (CT/PET Scans, MRIs)		Yes	Covered						
44	Preventive Care/Screening/Immunization		Yes	Covered								Preventive Care/Screening/Immunization		Yes	Covered						
45	Routine Foot Care											Routine Foot Care									
46	Acupuncture		Yes	Covered	Yes	12	Visit(s) per Year					Acupuncture		Yes	Covered	Yes	12	Visit(s) per Year			
47	Weight Loss Programs											Weight Loss Programs									
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 to 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			
51	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.	
52	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.	
53	Well Baby Visits and Care		Yes	Covered								Well Baby Visits and Care		Yes	Covered						
54	Laboratory Outpatient and Professional Services		Yes	Covered								Laboratory Outpatient and Professional Services		Yes	Covered						
55	X-rays and Diagnostic Imaging		Yes	Covered								X-rays and Diagnostic Imaging		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	Orthodontia – Child		Yes	Covered					Medically necessary orthodontia must be covered.			Orthodontia – Child		Yes	Covered					Medically necessary orthodontia must be covered.	
58	Major Dental Care – Child		Yes	Covered					Quantitative limits apply; see EHB base benchmark plan.			Major Dental Care – Child		Yes	Covered					Quantitative limits apply; see EHB base benchmark plan.	
59	Basic Dental Care – Adult											Basic Dental Care – Adult									
60	Orthodontia – Adult											Orthodontia – Adult									
61	Major Dental Care – Adult											Major Dental Care – Adult									
62	Abortion for Which Public Funding is Prohibited											Abortion for Which Public Funding is Prohibited									
63	Transplant		Yes	Covered								Transplant		Yes	Covered						
64	Accidental Dental											Accidental Dental									
65	Dialysis		Yes	Covered								Dialysis		Yes	Covered						
66	Allergy Testing											Allergy Testing									
67	Chemotherapy		Yes	Covered					Covered under the base benchmark plan.			Chemotherapy		Yes	Covered					Covered under the base benchmark plan.	
68	Radiation		Yes	Covered					Covered under the base 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).	
69	Diabetes Education		Yes	Covered								Diabetes Education		Yes	Covered						
70	Prosthetic Devices		Yes	Covered								Prosthetic Devices		Yes	Covered						
71	Infusion Therapy		Yes	Covered					Covered under applicable benefit (such as office visit).			Infusion Therapy		Yes	Covered					Covered under applicable benefit (such as office visit).	
72	Treatment for Temporomandibular Joint		Yes	Covered								Treatment for Temporomandibular Joint		Yes	Covered						
73	Nutritional Counseling		Yes	Covered								Nutritional Counseling		Yes	Covered						
74	Reconstructive Surgery		Yes	Covered					This coverage is required under the following laws: RCW 48.20.395, 48.20.430, 48.21.155, 48.21.230, 48.44.212, 48.44.330, 48.46.250, 48.46.280, WAC 284-43-878(3)(b)(i), and WAC 284-50-320(6)(e).			Reconstructive Surgery		Yes	Covered					Coverage for reconstructive breast surgery and treatment of congenital anomalies is required and is covered under the state base benchmark plan.	
75												Diabetes Care Management			Covered						Additional EHB Benefit
76												Inherited Metabolic Disorder - PKU			Covered						Additional EHB Benefit
77												Dental Anesthesia			Covered						Additional EHB Benefit

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	**Individual and Small Group Market Stand-Alone Pediatric Dental**																				
2																					
3	**Stand-Alone Pediatric Dental Required Changes**																				
4																					
5	**After Add-In File (7.2) Update**											**2018 Plan Year**									
6	***Benefit Information***		***General Information***									***Benefit Information***		***General Information***							
7	**Benefits**		**EHB**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Exclusions**	**Benefit Explanation**	**EHB Variance Reason**		**Benefits**		**EHB**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Exclusions**	**Benefit Explanation**	**EHB Variance Reason**
8	**Routine Dental Services (Adult)**											**Routine Dental Services (Adult)**									
9	**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			
10	**Basic Dental Care – Child**		Yes	Covered	Yes	1	Exam(s) per Year					**Basic Dental Care – Child**		Yes	Covered	Yes	1	Exam(s) per Year			
11	**Orthodontia – 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.			**Major Dental Care – Child**		Yes	Covered					Quantitative limits apply; see EHB base benchmark plan.	
13	**Basic Dental Care – Adult**											**Basic Dental Care – Adult**									
14	**Orthodontia – Adult**											**Orthodontia – Adult**									
15	**Major Dental Care – Adult**											**Major Dental Care – Adult**									
16	**Accidental Dental**											**Accidental Dental**									