

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
		Small Group Market																				
		After Add-In File (6.1) Update										2017 Plan Year										
Benefit Information										Benefit 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					
Primary Care Visit to Treat an Injury or Illness	Yes	Covered							Primary Care Visit to Treat an Injury or Illness	Yes	Covered											
Specialist Visit	Yes	Covered							Specialist Visit	Yes	Covered											
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered							Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered											
Outpatient Facility Fee (e.g., 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											
Hospice Services	Yes	Covered	Yes	14	Days per Lifetime				Hospice Services	Yes	Covered	Yes	14	Days per Lifetime								
Routine Dental Services (Adult)									Routine Dental Services (Adult)													
Infertility Treatment									Infertility Treatment													
Long-Term/Custodial Nursing Home Care									Long-Term/Custodial Nursing Home Care													
Private-Duty Nursing									Private-Duty Nursing													
Routine Eye Exam (Adult)									Routine Eye Exam (Adult)													
Urgent Care Centers or Facilities	Yes	Covered							Urgent Care Centers or Facilities	Yes	Covered											
Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year				Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year								
Emergency Room Services	Yes	Covered							Emergency Room Services	Yes	Covered											
Emergency Transportation/Ambulance	Yes	Covered							Emergency Transportation/Ambulance	Yes	Covered											
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered							Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered											
Inpatient Physician and Surgical Services	Yes	Covered							Inpatient Physician and Surgical Services	Yes	Covered											
Bariatric Surgery									Bariatric Surgery													
Cosmetic Surgery									Cosmetic Surgery													
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.						
Prenatal and Postnatal Care	Yes	Covered							Prenatal and Postnatal Care	Yes	Covered											
Delivery and All Inpatient Services for Maternity Care	Yes	Covered							Delivery and All Inpatient Services for Maternity Care	Yes	Covered											
Mental/Behavioral Health Outpatient Services	Yes	Covered							Mental/Behavioral Health Outpatient Services	Yes	Covered											
Mental/Behavioral Health Inpatient Services	Yes	Covered							Mental/Behavioral Health Inpatient Services	Yes	Covered											
Substance Abuse Disorder Outpatient Services	Yes	Covered							Substance Abuse Disorder Outpatient Services	Yes	Covered											
Substance Abuse Disorder Inpatient 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					
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					
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 habilitative services is limited to 25-outpatient visits/year.	Other Law/Regulation					
Chiropractic Care	Yes	Covered	Yes	10	Visit(s) per Year				Chiropractic Care	Yes	Covered	Yes	10	Visit(s) per Year								
Durable Medical Equipment	Yes	Covered							Durable Medical Equipment	Yes	Covered											
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.						
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											
Routine Foot Care	Yes	Covered	Yes	12	Visit(s) per Year				Routine Foot Care	Yes	Covered	Yes	12	Visit(s) per Year								
Acupuncture	Yes	Covered							Acupuncture	Yes	Covered											
Weight Loss Programs	Yes	Covered							Weight Loss Programs	Yes	Covered											
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								
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).						
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								
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.						
Well Baby Visits and Care	Yes	Covered							Well Baby Visits and Care	Yes	Covered											
Laboratory Outpatient and Professional Services	Yes	Covered							Laboratory Outpatient and Professional Services	Yes	Covered											
X-rays and Diagnostic Imaging	Yes	Covered							X-rays and Diagnostic Imaging	Yes	Covered											
Basic Dental Care - Child	Yes	Covered	Yes	1	Exam(s) per Year				Basic Dental Care - Child	Yes	Covered	Yes	1	Exam(s) per Year								
Orthodontia - Child	Yes	Covered					Medically necessary orthodontia must be covered.		Orthodontia - Child	Yes	Covered					Medically necessary orthodontia must be covered.						
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.						
Basic Dental Care - Adult									Basic Dental Care - Adult													
Orthodontia - Adult									Orthodontia - Adult													
Major Dental Care - Adult									Major Dental Care - Adult													
Abortion for Which Public Funding is Prohibited									Abortion for Which Public Funding is Prohibited													
Transplant	Yes	Covered							Transplant	Yes	Covered											
Accidental Dental	Yes	Covered							Accidental Dental	Yes	Covered											
Dialysis	Yes	Covered							Dialysis	Yes	Covered											
Allergy Testing	Yes	Covered					Covered under the base benchmark plan.		Allergy Testing	Yes	Covered					Covered under the base benchmark plan.						
Chemotherapy	Yes	Covered					Covered under the base benchmark plan; covered under applicable benefit (such as office visit).		Chemotherapy	Yes	Covered					Covered under the base benchmark plan; covered under applicable benefit (such as office visit).						
Radiation	Yes	Covered							Radiation	Yes	Covered											
Diabetes Education	Yes	Covered							Diabetes Education	Yes	Covered											
Prosthetic Devices	Yes	Covered							Prosthetic Devices	Yes	Covered											
Influsion Therapy	Yes	Covered					Covered under applicable benefit (such as office visit).		Influsion Therapy	Yes	Covered					Covered under applicable benefit (such as office visit).						
Treatment for Temporomandibular Joint	Yes	Covered							Treatment for Temporomandibular Joint	Yes	Covered											
Nutritional Counseling	Yes	Covered							Nutritional Counseling	Yes	Covered											
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 284-43-078(3)(b)(i), and WAC 284-60-020(b)(i).		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.							
									Disease Care Management									Additional EHB Benefit				
									Inherited Metabolic Disorder - PKU									Additional EHB Benefit				
									Dental Anesthesia									Additional EHB Benefit				

