



# The State's EHB-benchmark Plan's Benefits and Limits

OMB Control Number: 0938-1174  
Expiration Date: 02/28/2024

**Instructions:** All fields on this template that are marked red are required to be completed. To ensure that this Benefits and Limits Summary Template corresponds with the EHB-benchmark plan document, please indicate the page number in which the benefit is covered under Column H if answering "Covered" under Column C (for example, "Covered" in Column C, "pg. 12" in Column H). If there is a quantitative limit on a benefit, then complete the Limit Quantity and Limit Unit fields. If there are no exclusions for a benefit, then leave the Exclusions field blank. Add an explanation in Column H to provide more details on a benefit.

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				Pg. 4
Specialist Visit	Yes	Covered	No				Pg. 4
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				Pg. 4
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				Pg. 7
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				Pg. 5
Hospice Services	Yes	Covered	Yes	14	Day(s) per Lifetime		Pg. 7
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Covered	No			Only evaluations to determine if and why a covered member is infertile and artificial insemination are covered.	Pg. 7
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				
Urgent Care Centers or Facilities	Yes	Covered	No				Pg. 18
Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year		Pg. 7
Emergency Room Services	Yes	Covered	No				Pg. 6
Emergency Transportation/Ambulance	Yes	Covered	No				Pg. 5
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				Pg. 7
Inpatient Physician and Surgical Services	Yes	Covered	No				Pg. 5
Bariatric Surgery	No	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				Pg. 12 and pg. 19 Covers cosmetic surgery when medically necessary.
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year		Pg. 16 Coverage is limited to 60-inpatient days/year.
Prenatal and Postnatal Care	Yes	Covered	No				Pg. 7
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				Pg. 7
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				Pg. 8
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				Pg. 8
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				Pg. 17
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				Pg. 17

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Generic Drugs	Yes	Covered	Yes	30	Days per Month		Pg. 15 Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill. For prescription contraceptive drugs coverage includes a twelve-month refill of contraceptive drugs obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee must receive a smaller supply.
Preferred Brand Drugs	Yes	Covered	Yes	30	Days per Month		Pg. 15 Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill. For prescription contraceptive drugs coverage includes a twelve-month refill of contraceptive drugs obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee must receive a smaller supply.
Non-Preferred Brand Drugs	Yes	Covered	Yes	30	Days per Month		Pg. 15 Coverage is limited to a 30-day supply retail or 90-day supply mail order per fill or refill. For prescription contraceptive drugs coverage includes a twelve-month refill of contraceptive drugs obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee must receive a smaller supply.
Specialty Drugs	Yes	Covered	Yes	30	Days per Month		Pg. 14 and pg. 15 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.
Outpatient Rehabilitation Services	Yes	Covered	Yes	25	Visit(s) per Year		Pg. 16

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Habilitation Services	Yes	Covered	Yes	30	Day(s) per Year		Pg. 6 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		Pg. 16 and 17
Durable Medical Equipment	Yes	Covered	No				Pg. 6
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years	An annual hearing exam and one hearing aid per ear every 3 years is covered. Cochlear Implants for children are also covered.	Pg. 6 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				Pg. 5
Preventive Care/Screening/Immunization	Yes	Covered	No				Pg. 4
Routine Foot Care	Yes	Covered	No				Pg. 6
Acupuncture	Yes	Covered	No				Pg. 5
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Year		Pg. 13
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Year		Pg. 14 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		Pg. 9
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Day(s) per Year		Pg. 16 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.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Day(s) per Year		Pg. 16 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.
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 EHB base benchmark plan for details.	Pg. 8 Human donor milk must be covered as it is covered by the state base benchmark plan.
Laboratory Outpatient and Professional Services	Yes	Covered	No				Pg. 5
X-rays and Diagnostic Imaging	Yes	Covered	No				Pg. 5
Basic Dental Care - Child	Yes	Covered	No			Exclusions apply - see EHB base benchmark plan.	Pg. 9 and 10

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Orthodontia - Child	Yes	Covered	No			Orthodontia that is not medically necessary.	Pg. 11 and pg. 13 Medically necessary orthodontia must be covered.
Major Dental Care - Child	Yes	Covered	No			Exclusions apply - see EHB base benchmark plan.	Pg. 10 and 11 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	Yes	Covered	No				Pg. 7 Coverage includes termination of pregnancy for all members.
Transplant	Yes	Covered	No				Pg. 18
Accidental Dental	No	Not Covered	No				
Dialysis	Yes	Covered	No				Pg. 6
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).	Pg. 14 Covered under the base benchmark plan.
Radiation	Yes	Covered	No				Pg. 5 Covered under the base benchmark plan; covered under applicable benefit (such as office visit).
Diabetes Education	Yes	Covered	No				Pg. 5
Prosthetic Devices	Yes	Covered	No				Pg. 16
Infusion Therapy	Yes	Covered	No				Pg. 4 Covered under applicable benefit (such as office visit).
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				Pg. 13 and 18
Nutritional Counseling	Yes	Covered	No				Pg. 9
Reconstructive Surgery	Yes	Covered	No				Pg. 16 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				Pg. 6 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.
Diabetes Care Management	Yes	Covered	No				Pg. 5
Inherited Metabolic Disorder – PKU	Yes	Covered	No				Pg. 7

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Dental Anesthesia	Yes	Covered	No				Pg. 5

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