

CMS CENTER FOR MEDICARE & MEDICAID SERVICES CENTER FOR CONSUMER INFORMATION & INSURANCE COVERAGE The State's EHB-benchmark Plan's Benefits and Limits							
Instructions: All fields on this template are required. 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				
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	No				
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Covered	No				Limitations vary based on procedures
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	No			Inpatient Private Duty Nursing Service is not covered	
Routine Eye Exam (Adult)	No	Not Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	No	Not Covered	No				
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	Yes	Covered	No				
							Cosmetic surgery for the correction of the congenital deformities or for conditions resulting from accidental injuries, scars, tumors or disease is covered.
Cosmetic Surgery	Yes	Covered	No				
Skilled Nursing Facility	Yes	Covered	No				
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				
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				
Outpatient Rehabilitation Services	Yes	Covered	No				Maintenance therapies not covered
Habilitation Services	Yes	Covered	No				Treatment must be medically necessary and therapeutic and not investigational.
Chiropractic Care	Yes	Covered	Yes	25	Visit(s) per Benefit Period		
Durable Medical Equipment	Yes	Covered	No				
					Visit(s) per 3 Years		
Hearing Aids	Yes	Covered	Yes	2			Benefits are for bone anchored hearing aids. Quantity limit applies to hearing aids for children.
Imaging (CT/PET Scans, MRIs)	No	Covered	No				Benefit provided for outpatient services and when these services are related to surgery or medical.
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	Yes	Covered	No				Only covered for persons diagnosed with diabetes
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Benefit Period		
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Benefit Period		
Dental Check-Up for Children	Yes	Covered	No				
							When rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrom) attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s). Maintenance Speech Therapy is not covered.
Rehabilitative Speech Therapy	Yes	Covered	No				
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	No				Maintenance Occupational and Physical Therapy are not covered.
Well Baby Visits and Care	Yes	Covered	No				
							Benefit provided for outpatient services and when these services are related to surgery or medical care.
Laboratory Outpatient and Professional Services	Yes	Covered	No				
							Benefit provided for outpatient services and when these services are related to surgery or medical care.
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	No				Limitations vary based on procedures
Orthodontia - Child	Yes	Covered	No				Limitations vary based on procedures
Major Dental Care - Child	Yes	Covered	No				
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Covered	No				
							Abortions are only covered when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
Abortion for Which Public Funding is Prohibited	No	Not Covered	No				
Transplant	Yes	Covered	No				
Accidental Dental	Yes	Covered	No				
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
							Services must be rendered by a physician, or duly certified, or licensed health care professional with expertise in diabetes management.
Diabetes Education	Yes	Covered	No				
Prosthetic Devices	Yes	Covered	No				
Infusion Therapy	Yes	Covered	No				
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				
Nutritional Counseling	Yes	Covered	No				
Reconstructive Surgery	Yes	Covered	No				Only includes benefits for mastectomy-related services.

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PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1174. The time required to complete this information collection is estimated to average 47 hours or 2,820 minutes per response for States and .5 hours or 30 minutes per response for Stand Alone Dental Plans. This time includes preparing, reviewing and submitting required documents. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.