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

OMB Control Number: 0938-1174
Expiration Date: XX/XX/2021

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				
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				Care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. Hospice respite care has a quantity limit of 15 inpatient days and 15 outpatient days per lifetime. Hospice respite care must be used in increments of not more than five days at a time.
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	No	Not Covered	No				
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	No				Plan refers to home skilled nursing as private duty nursing. Home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting.
Routine Eye Exam (Adult)	No	Not Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	Yes	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				Surgery must be medically necessary. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is required.
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	90	Day(s) per Benefit Period		
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				

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Mental/Behavioral Health Inpatient Services	Yes	Covered	No				
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				
Substance Abuse Disorder Inpatient Services	Yes	Covered	Yes	90	Day(s) per Lifetime	Excludes treatment received in a residential treatment facility, except the acute level of care described in plan document.	Quantity Limit: 30 days/six-month period for inpatient treatment and 90 days/lifetime for inpatient treatment for alcoholism treatment. Quantity Limit for all other substance abuse inpatient treatment: 30 days/benefit year for inpatient treatment.
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				
Habilitation Services	Yes	Covered	Yes				Treatment for Autism Spectrum Disorder (ASD) with speech therapy, occupational therapy, or physical therapy is covered. Use of Applied Behavioral Analysis (ABA) for the treatment of ASD is covered with the following minimum coverage limits: 1) through age 6: 1300 hours per benefit period; 2) ages 7-13: 900 hours per benefit period; 3) ages 14-18: 450 hours per benefit period.
Chiropractic Care	Yes	Covered	No				
Durable Medical Equipment	Yes	Covered	No				Equipment must primarily and customarily serve a medical purpose. Issuer determines whether to pay the rental amount or the purchase price amount for an item and determine the length of any rental term.
Hearing Aids	No	Not Covered	No				
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				
Preventive Care/Screening/Immunization	Yes	Covered	No			Excludes: periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.	
Routine Foot Care	No	Not Covered	No				
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				
Eye Glasses for Children	Yes	Covered	No				
Dental Check-Up for Children	Yes	Covered	No				

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Rehabilitative Speech Therapy	Yes	Covered	No			Excludes: speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.	Coverage includes rehabilitative speech therapy services when related to a specific illness, injury or impairment and involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	No				Occupational therapy is only covered insofar as services to treat the upper extremities, which means the arms from the shoulders to the fingers.
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				
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	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Not Covered	No				Plan covers complications of pregnancy such as an ectopic pregnancy that is terminated or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.
Transplant	Yes	Covered	No			Excludes: expenses of transporting a living donor, expenses related to the purchase of any organ, and services or supplies related to mechanical or non-human organs associated with transplants.	Transplants are subject to Case Management
Accidental Dental	Yes	Covered	No				Treatment must be completed within 12 months of the injury.
Dialysis	Yes	Covered	No				
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	Yes				Quantity Limit: Two certified diabetes education programs per member per lifetime, and eight visits per benefit year for follow-up training once patient has participated in a diabetes education program.
Prosthetic Devices	Yes	Covered	No				

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Infusion Therapy	Yes	Covered	No				Infusion therapy is covered when provided in the home (home infusion therapy).
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No			Excludes: dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.	
Nutritional Counseling	No	Not Covered	No				
Reconstructive Surgery	Yes	Covered	No				