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

OMB Control Number: 0938-1174
Expiration Date: 11/30/2027

Instructions: All fields in columns B, C, and D 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. 4-6
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				pg. 4-6
Hospice Services	Yes	Covered	No				pg. 17-18
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Covered	Yes	3	Sperm/egg retrieval and embryo creation attempts	following limits: 3 attempts to retrieve sperm or eggs; 3 attempts to create embryos; 3 rounds of pre-transfer testing of gametes or embryos; 2 years of storage for embryos; 2 vials of donor sperm; 10 donor eggs	pg. 14-15 A comprehensive list of coverages is included in the Plan Document.
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. 5
Home Health Care Services	Yes	Covered	Yes	100	Visits per year	Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility Care. Excludes care in the home if the home is not a safe and effective treatment setting.	pg. 16-17 Covered if you are confined to a home, your condition requires the services of a healthcare professional, and your services are approved by an in-network provider.
Emergency Room Services	Yes	Covered	No				pg. 5
Emergency Transportation/Ambulance	Yes	Covered	No			Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered.	pg. 7-8 Ground and air ambulances are covered for emergencies, and for nonemergencies when approved by an in-network physician.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				pg. 6-7
Inpatient Physician and Surgical Services	Yes	Covered	No				pg. 6-7
Bariatric Surgery	Yes	Covered	No				pg. 5, 7-8
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	100	Day(s) per benefit period		pg. 26-27
Prenatal and Postnatal Care	Yes	Covered	No				pg. 4
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				pg. 6
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				pg. 18-19
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				pg. 18-19
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				pg. 18-19
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				pg. 18-19
Generic Drugs	Yes	Covered	No				pg. 21-22
Preferred Brand Drugs	Yes	Covered	No				pg. 21-22
Non-Preferred Brand Drugs	Yes	Covered	No				pg. 21-22
Specialty Drugs	Yes	Covered	No				pg. 21-22
Outpatient Rehabilitation Services	Yes	Covered	No			Items and services that are not health care items and services (e.g., respite care, day care, recreational care, social services, custodial care, or education services of any kind, including vocational training.	pg. 24-25
Habilitation Services	Yes	Covered	No			Items and services that are not health care items and services (e.g., respite care, day care, recreational care, social services, custodial care, or education services of any kind, including vocational training.	pg. 24-25 Covered even if 100% functionality is not possible.
Chiropractic Care	No	Not Covered	No				
Durable Medical Equipment	Yes	Covered	No			Comfort, convenience, or luxury equipment or features; repair or replacement of equipment due to loss or misuse. Does not include neuromodulators.	pg. 13-14 For use outside of an institutional setting. A comprehensive list of coverages is included in the Plan Document.
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. 15-16
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				pg. 6, 20
Preventive Care/Screening/Immunization	Yes	Covered	No				pg. 4
Routine Foot Care	Yes	Covered	No				pg. 23
Acupuncture	Yes	Covered	No			Covered only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.	pg. 5
Weight Loss Programs	Yes	Covered	No				pg. 15
Routine Eye Exam for Children	Yes	Covered	No			Industrial frames, eyeglass lenses and frames, contact lenses, including fitting and dispensing (except for special contact lenses to treat aphakia or aniridia), eye exams for the purposes of obtaining or maintaining contact lenses, low-vision devices.	pg. 28-29

Eye Glasses for Children	Yes	Covered	No				pg. 28-29 Special contact lenses for aniridia, and for aphakia through age 9, are covered. Otherwise, pediatric vision services are covered pursuant to the benefits offered under the Federal Employees Dental and Vision Insurance Program.
Dental Check-Up for Children	Yes	Covered	No				pg. 11
Rehabilitative Speech Therapy	Yes	Covered	No				pg. 24
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	No				pg. 24-25
Well Baby Visits and Care	Yes	Covered	No				pg. 4
Laboratory Outpatient and Professional Services	Yes	Covered	No				pg. 20
X-rays and Diagnostic Imaging	Yes	Covered	No				pg. 20
Basic Dental Care - Child	Yes	Covered	No				pg. 11 Pediatric dental services are considered an EHB and are covered by plans pursuant to the Health Families 2011-2012 CHIP benefits.
Orthodontia - Child	Yes	Covered	No			Only for services related to cleft palate.	pg. 11 Dental and orthodontic services for cleft palate, if services are integral part of reconstructive surgery for cleft palate covered under reconstructive surgery by the Benchmark Plan, a plan provider or authorized non-plan provider who is a dentist or orthodontist provides the services.
Major Dental Care - Child	Yes	Covered	No			Only for services related to radiation therapy and cleft palate--anesthesia as described in Explanation	pg. 11 Dental services for radiation treatment.
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Covered	No			Only for services related to cleft palate.	pg. 11-12 Orthodontia for clef palate as described above.
Major Dental Care – Adult	No	Covered	No			Only services related to cleft palate or as necessary to prepare the jaw for radiation therapy of cancer in the head or neck.	pg. 11-12 Dental services for radiation treatment. Dental Services for cleft palate as described above.
Abortion for Which Public Funding is Prohibited	No	Covered	No				
Transplant	Yes	Covered	No				pg. 27-28 Coverage will cease if it is determined the patient does not qualify for a transplant.
Accidental Dental	No	Not Covered	No				
Dialysis	Yes	Covered	No			Comfort, convenience, or luxury equipment, supplies and features. Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel.	pg. 12-13 Dialysis services are covered if they meet the plan's listed criteria.
Allergy Testing	Yes	Covered	No				pg. 5
Chemotherapy	Yes	Covered	No				pg. 5
Radiation	Yes	Covered	No				pg. 20
Diabetes Education	Yes	Covered	No				pg. 15
Prosthetic Devices	Yes	Covered	No			The plan does not cover the following: multifocal intraocular lenses and intraocular lenses to correct astigmatism; nonrigid supplies, such as elastic stockings and wigs, unless otherwise noted; comfort, convenience, or luxury equipment or features; shoes or arch supports unless otherwise noted; repair or replacement of a device due to loss or misuse.	pg. 22-23 The following prosthetic and orthotic devices are covered: -internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, hip joints, if implanted during a surgery the plan is covering. -prosthetic devices/installation accessories to restore method of speaking following removal of larynx -prostheses needed after Medically Necessary mastectomy & three brassieres required to hold prosthesis every 12 months -compression burn garments and lymphedema wraps and garments -enteral formula for members who require tube feeding w/in Medicare guidelines - prostheses to replace all or part of external facial body part removed or impaired as result of disease, injury, or congenital defect.
Infusion Therapy	Yes	Covered	No				pg. 14, 18
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				pg. 28
Nutritional Counseling	Yes	Not Covered	No				pg. 15 Nutritional counseling for diabetese prevention and control and for people receiving hospice services.
Reconstructive Surgery	Yes	Covered	No			Surgery that, in the judgment of the plan's physician specializing in reconstructive surgery, offers only minimal improvement in appearance. Surgery that is performed solely to alter or reshape normal structures of the body to improve appearance.	pg. 23-24