



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

OMB Control Number: 0938-1174  
Expiration Date: 06/01/2021

**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				p. 27
Specialist Visit	Yes	Covered	No				p. 27
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				p. 27
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				p. 26-27
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				p. 27
Hospice Services	Yes	Covered	No				p. 22
Routine Dental Services (Adult)	No	Not Covered	No				p. 15
Infertility Treatment	Yes	Covered	No				p. 23-24 Diagnosis and medically indicated treatments for physical conditions causing infertility
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				p. 23
Private-Duty Nursing	No	Not Covered	No				p. 19
Routine Eye Exam (Adult)	No	Not Covered	No				p. 21
Urgent Care Centers or Facilities	Yes	Covered	No				p. 17
Home Health Care Services	Yes	Covered	Yes	100	Day(s) per Year		p. 19
Emergency Room Services	Yes	Covered	No				p. 17
Emergency Transportation/Ambulance	Yes	Covered	No				p. 9-10
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				p.23
Inpatient Physician and Surgical Services	Yes	Covered	No				p. 23
Bariatric Surgery	Yes	Covered	No				p. 11 Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related comorbid medical conditions.
Cosmetic Surgery	No	Not Covered	No				p. 14
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year		p. 28
Prenatal and Postnatal Care	Yes	Covered	No				p. 24-25
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				p. 24-25
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				p. 25-26
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				p.25-26
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				p. 25-26
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				p. 25-26
Generic Drugs	Yes	Covered	No				p. 29-30
Preferred Brand Drugs	Yes	Covered	No				p. 29-30
Non-Preferred Brand Drugs	Yes	Covered	No				p. 29-30
Specialty Drugs	Yes	Covered	No				p. 29-30
Outpatient Rehabilitation Services	Yes	Covered	No				p. 28-29
Habilitation Services	Yes	Covered	No				p. 18
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year		p. 13 Unless for Habilitative and Rehabilitative Services
Durable Medical Equipment	Yes	Covered	No				p. 19-22
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years		p. 19 Per ear

Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				p. 23
Preventive Care/Screening/Immunization	Yes	Covered	No				p. 30-32 Shall include artery calcification testing for the diagnosis of heart disease
Routine Foot Care	No	Not Covered	No				p. 17
Acupuncture	Yes	Covered	Yes	20	Visit(s) per Year		p. 9 Unless for Habilitative and Rehabilitative Services
Weight Loss Programs	Yes	Covered	No				p. 35 Includes coverage for drugs and programs if medically necessary for morbid obesity and obesity.
Routine Eye Exam for Children	Yes	Covered	No				p. 31
Eye Glasses for Children	Yes	Covered	No				p. 31
Dental Check-Up for Children	Yes	Covered	No				p. 15
Rehabilitative Speech Therapy	Yes	Covered	No				p. 28-29
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	No				p. 28-29
Well Baby Visits and Care	Yes	Covered	No				p. 31-32
Laboratory Outpatient and Professional Services	Yes	Covered	No				p. 23
X-rays and Diagnostic Imaging	Yes	Covered	No				p. 23
Basic Dental Care - Child	Yes	Covered	No				p. 15
Orthodontia - Child	Yes	Covered	No				p. 15
Major Dental Care - Child	Yes	Covered	No				p. 15-16
Basic Dental Care - Adult	No	Not Covered	No				p. 15-16
Orthodontia - Adult	No	Not Covered	No				p. 15-16
Major Dental Care – Adult	No	Not Covered	No				p. 15-16
Abortion for Which Public Funding is Prohibited	No	Not Covered	No				p. 35
Transplant	Yes	Covered	No				p.33-34
Accidental Dental	Yes	Covered	No				p. 14-15
Dialysis	Yes	Covered	No				p. 26
Allergy Testing	Yes	Covered	No				p. 9
Chemotherapy	Yes	Covered	No				p. 13
Radiation	Yes	Covered	No				p. 13
Diabetes Education	Yes	Covered	No				p. 16 Benefits are available when received from a Practitioner/Provider who is approved to provide diabetes education.
Prosthetic Devices	Yes	Covered	No				p.19-21
Infusion Therapy	Yes	Covered	No				p. 19
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				p. 15

						<p>p. 26, Covered: The following are covered benefits:</p> <ul style="list-style-type: none"> <li>• Nutritional supplements for prenatal care when prescribed by a practitioner/provider are covered for pregnant women.</li> <li>• Nutritional counseling as medically necessary</li> <li>• Nutritional supplements that require a prescription to be dispensed are covered when prescribed by a Practitioner/Provider and when medically necessary to replace a specific documented deficiency.</li> <li>• Nutritional supplements administered by injection at the practitioner's/provider's office are covered when medically necessary.</li> <li>• Enteral formulas or products, as nutritional support, are covered only when prescribed by a practitioner/provider and administered by enteral tube feedings.</li> <li>• Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is covered when ordered by a</li> </ul>
Nutritional Counseling	Yes	Covered	No			
Reconstructive Surgery	Yes	Covered	No			p. 33

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