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 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	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.
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				
Hearing Aids	Yes	Covered	Yes	2	Visit(s) per 3 Years		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				
Rehabilitative Speech Therapy	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). Maintenace Speech Therapy is not covered.
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				
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				Benefit provided for outpatient services and when these services are related to surgery or medical care.
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				Limitations vary based on procedures
Major Dental Care - Child	Yes	Covered	No				Limitations vary based on procedures
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Covered	No				
Abortion for Which Public Funding is Prohibited	No	Not 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.
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				
Diabetes Education	Yes	Covered	No				Services must be rendered by a physician, or duly certified, or licensed health care professional with expertise in diabetes management.
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.