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

OMB Control Number: 0938-1174
Expiration Date: 02/28/2024

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				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 5.
Specialist Visit	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 5.
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 5.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 20.
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 20.
Hospice Services	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 14-15.
Routine Dental Services (Adult)	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 10.
Infertility Treatment	No	Not Covered	No			• medications for treatment of infertility when used for treatment of infertility; and • surgical, radiological, pathological or laboratory procedures leading to or in connection with: – artificial insemination; – in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT); ozygote intrafallopian transfer (ZIFT); and – any variations of the above procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.	Evaluations to determine if and why a covered member is infertile are covered. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 15.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 33.
Private-Duty Nursing	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 14.
Routine Eye Exam (Adult)	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 29.
Urgent Care Centers or Facilities	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 5.
Home Health Care Services	Yes	Covered	No			• homemaker services; • drugs or medications except as otherwise noted; • Custodial Care; • food or home-delivered meals; • non-medical charges; and • private duty nursing services provided at the same time as home health care nursing services.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 13- 14.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Emergency Room Services	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 12.
Emergency Transportation/Ambulance	Yes	Covered	No			• when a Covered Person can be safely transported by any other means; and • when transportation is solely for the convenience of the Provider, family, or Covered Person.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 6.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 15-16.
Inpatient Physician and Surgical Services	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 15-16.
Bariatric Surgery	Yes	Covered	No			Health plans may limit coverage to specific Health Care Facilities for clinical quality purposes.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 6.
Cosmetic Surgery	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 9-10.
Skilled Nursing Facility	Yes	Covered	No			• Custodial Care; • cognitive re-training or educational programs.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 24.
Prenatal and Postnatal Care	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 16.
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 16.
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			• services ordered by a court of law (unless Medically Necessary); • treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required; • non-traditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories; • services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization or delinquency, as noted in General Exclusions; • Custodial Care, as noted in General Exclusions; • psychoanalysis; • hypnotherapy; and • biofeedback, pain management, stress reduction classes and pastoral counseling.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 19- 20.
Mental/Behavioral Health Inpatient Services	Yes	Covered	No			• services ordered by a court of law (unless Medically Necessary); • treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required; • non-traditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories; • services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization or delinquency, as noted in General Exclusions; • Custodial Care, as noted in General Exclusions; • psychoanalysis; • hypnotherapy; and • biofeedback, pain management, stress reduction classes and pastoral counseling.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 19- 20.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			• services ordered by a court of law (unless deemed Medically Necessary); • non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories; • treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required; • services, including long-term residential programs, adventure-based activities, wilderness programs, and residential programs that focus on education, socialization, or delinquency; • Custodial Care, as noted in General Exclusions; • biofeedback, pain management, stress reduction classes, and pastoral counseling; • psychoanalysis; and • hypnotherapy.	Health plans may limit coverage of substance use disorder treatment services to Medically Necessary Care in the least restrictive setting. Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 24-25.
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			• services ordered by a court of law (unless deemed Medically Necessary); • non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories; • treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required; • services, including long-term residential programs, adventure-based activities, wilderness programs, and residential programs that focus on education, socialization, or delinquency; • Custodial Care, as noted in General Exclusions; • biofeedback, pain management, stress reduction classes, and pastoral counseling; • psychoanalysis; and • hypnotherapy.	Health plans may limit coverage of substance use disorder treatment services to Medically Necessary Care in the least restrictive setting. Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 24-25.
Generic Drugs	Yes	Covered	No			• all medications for treatment of infertility; • refills beyond one year from the original prescription date; • devices of any type other than prescription contraceptives and insulin pumps, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances, and supports (although benefits may be provided under other sections of this EHB Benchmark); • any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials; • Viagra, Cialis, Levitra, Addyi, and other drugs to treat sexual dysfunction; • vitamins, except those which, by law, require a prescription; • drugs that do not require a prescription, even if prescribed or recommended by a Provider; • any drugs excluded under the health plan's formulary drug list. Covered Persons may request benefit exceptions.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 20-23.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Preferred Brand Drugs	Yes	Covered	No			• all medications for treatment of infertility; • refills beyond one year from the original prescription date; • devices of any type other than prescription contraceptives and insulin pumps, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances, and supports (although benefits may be provided under other sections of this EHB Benchmark); • any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials; • Viagra, Cialis, Levitra, Addyi, and other drugs to treat sexual dysfunction; • vitamins, except those which, by law, require a prescription; • drugs that do not require a prescription, even if prescribed or recommended by a Provider; • any drugs excluded under the health plan's formulary drug list. Covered Persons may request benefit exceptions.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 20-23.
Non-Preferred Brand Drugs	Yes	Covered	No			• all medications for treatment of infertility; • refills beyond one year from the original prescription date; • devices of any type other than prescription contraceptives and insulin pumps, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances, and supports (although benefits may be provided under other sections of this EHB Benchmark); • any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials; • Viagra, Cialis, Levitra, Addyi, and other drugs to treat sexual dysfunction; • vitamins, except those which, by law, require a prescription; • drugs that do not require a prescription, even if prescribed or recommended by a Provider; • any drugs excluded under the health plan's formulary drug list. Covered Persons may request benefit exceptions.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 20-23.
Specialty Drugs	Yes	Covered	No			• all medications for treatment of infertility; • refills beyond one year from the original prescription date; • devices of any type other than prescription contraceptives and insulin pumps, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances, and supports (although benefits may be provided under other sections of this EHB Benchmark); • any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials; • Viagra, Cialis, Levitra, Addyi, and other drugs to treat sexual dysfunction; • vitamins, except those which, by law, require a prescription; • drugs that do not require a prescription, even if prescribed or recommended by a Provider; • any drugs excluded under the health plan's formulary drug list. Covered Persons may request benefit exceptions.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 20-23.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Outpatient Rehabilitation Services	Yes	Covered	Yes	30	Visit(s) per Year	• Custodial Care; • cognitive re-training or educational programs.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 23-24.
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Year	• Custodial Care; • cognitive re-training or educational programs.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 23-24.
Chiropractic Care	Yes	Covered	No			• services, including modalities, that do not require the constant attendance of a Chiropractor; • treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature; • acupuncture; • hot and cold packs; • massage therapy; • care provided but not documented with clear, legible notes indicating the patient's symptoms, physical findings, the Chiropractor's assessment, and treatment modalities used (billed); • low-level laser therapy; • vertebral axial decompression; • supplies or Durable Medical Equipment; • treatment of a mental health condition; • prescription or administration of drugs; • obstetrical procedures including prenatal and post-natal care; • Custodial Care; • supervised services or modalities that any other procedure not listed as a Covered chiropractic service.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 7-8.
Durable Medical Equipment	Yes	Covered	No			• treatment for hair loss; • items or equipment that are not DME; • any treatment, DME, supplies, or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience; and • repair or replacement of dental appliances or dental prosthetics except as listed above. • dental appliances or dental prosthetics, except as listed above; • shoe insert orthotics, lifts, arch supports, or special shoes not attached to a brace (except with a diagnosis of diabetes); • custom-fabricated or custom-molded knee braces for which Covered Persons have not received Prior Approval; • duplicate medical equipment and supplies, orthotics, and prosthetics; • dynamic splinting, patient-actuated end-range motion stretching devices and programmable or variable motion resistance devices;	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 16- 19.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years	Health plans may limit coverage to one of the following conditions: • hearing loss in the better ear is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz; • unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz; and/or • hearing loss in the better ear is greater than 40dB, based on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72%. Health plans may limit coverage of hearing aids to one hearing aid per ear every three years for specified degree of hearing loss. Health plans may also limit coverage of hearing aid repairs to 50% of the replacement cost.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 13.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 12.
Preventive Care/Screening/Immunization	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 5.
Routine Foot Care	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 33.
Acupuncture	No	Not Covered	No				Acupuncture exclusion does not apply to Medically Necessary services that would otherwise be Covered services when such services are performed by a naturopath and within the scope of the naturopathic Provider's license. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 31.
Weight Loss Programs	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 34.
Routine Eye Exam for Children	Yes	Covered	Yes	1	Visit(s) per Year		Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 28- 30.
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Year		Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 28- 30.
Dental Check-Up for Children	Yes	Covered	No				Class I services including examinations and cleanings. Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 10-11.
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Year	Speech Therapy performed in a group setting;	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 26-27.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Year	• care for which there is no therapeutic benefit or likelihood of improvement; • care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the result of treatment or the individual's medical progress; • care provided, but not documented with clear, legible notes indicating the Covered Person's symptoms, physical findings, the Provider's assessment, and treatment modalities used (billed); • group physical medicine services, group exercise, or Physical or Occupational Therapy performed in a group setting; • therapy services provided as part of Custodial Care; • services, including modalities, that do not require the constant attendance of a Provider; • hot and cold packs; • supervised services or modalities that do not require the skill and expertise of a licensed Provider; or • unattended services or modalities (application of a service or modality) that do not require one-on-one patient	Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 26- 27.
Well Baby Visits and Care	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 16.
Laboratory Outpatient and Professional Services	Yes	Covered	No			Health plans may limit coverage of laboratory and pathology tests, including genetic testing and molecular pathology procedures, to in-network laboratories.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 12.
X-rays and Diagnostic Imaging	Yes	Covered	No				Health plans may require Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS, PET scans, and echocardiograms), polysomnography (sleep studies) as determined by the plan. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 12.
Basic Dental Care - Child	Yes	Covered	No				Class II (basic) services including simple restoration (fillings), crowns and jackets, repair of crowns, wisdom tooth removal, extractions, and endodontics (root canal). Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 11.
Orthodontia - Child	Yes	Covered	No				Orthodontia Medically Necessary for the treatment of a medical condition is covered. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 11.
Major Dental Care - Child	Yes	Covered	No			• Surgical removal of teeth, including removal of wisdom teeth; • gingivectomy; • tooth implants, including those for the purpose of anchoring oral appliances, unless for the treatment of an accidental injury, trauma, or cancer- related treatment; • care for periodontitis; • injury to teeth or gums as a result of chewing or biting; • pre- and post-operative dental care; • orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery or in connection with an accidental injury); • procedures designed primarily to prepare the mouth for dentures; or • charges related to non-Covered dental procedures or anesthesia.	• Class III (major) services including dentures, bridges, replacement of bridges and dentures, and Medically Necessary orthodontia; and/or • Facility and anesthesia charges are covered to the extent required by 8 V.S.A. § 4100i for all Covered Persons. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 11.
Basic Dental Care - Adult	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 32-33.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Orthodontia - Adult	No	Not Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 32-33.
Major Dental Care – Adult	No	Not Covered	No				Facility and anesthesia charges are covered to the extent required by 8 V.S.A. § 4100i for all Covered Persons. Please see State of Vermont Essential Health Benefit Plan, pg. 11.
Abortion for Which Public Funding is Prohibited	No	Covered	No				Abortion and any related services, drugs, or supplies are covered. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 5.
Transplant	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 27-28.
Accidental Dental	Yes	Covered	No				The following services are covered for Covered Persons over age 21: • treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident; • surgery to correct gross deformity resulting from major disease or Surgery (Surgery must take place within six months of the onset of disease or within six months after Surgery, except as otherwise required by law); • surgery related to head or neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer; • treatment for a congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel; and • facility and anesthesia charges for Covered Persons with severe disabilities that preclude office-based dental care due to safety considerations. Please see State of Vermont Essential Health Benefit Benchmark Plan, pg. 10.
Dialysis	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 26.
Allergy Testing	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 12.
Chemotherapy	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 26.
Radiation	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 26.
Diabetes Education	Yes	Covered	No				As required by 8 V.S.A. § 4089c, coverage includes equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes, and non-insulin using diabetes. Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 11-12.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Prosthetic Devices	Yes	Covered	No			Health plans may limit replacement of wigs (cranial/scalp prosthesis) to one wig every three years. Health plans may limit coverage of eyeglasses or contact lenses to: • treatment of aphakia or keratoconus; • one set of accompanying eyeglasses or contact lenses for the original prescription; and • one set for each new prescription. Health plans may limit coverage of dental prostheses to those required: Health plans may limit coverage of dental prostheses to those required: • to treat an accidental injury (except injury as a result of chewing or biting); • to correct gross deformity resulting from major disease, congenital anomalies that result in impaired physical function or Surgery; • to treat obstructive sleep apnea; or • to treat craniofacial disorders, including temporomandibular joint syndrome.	The purchase, fitting, necessary adjustments, repairs, and replacements of prosthetics is covered, including prosthetic devices that are attached to (or inserted into) prosthetic shoes, and prosthetics which otherwise replace a missing body part. Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 17-18.
Infusion Therapy	Yes	Covered	No			Health plans may limit coverage of home infusion therapy to: • a prescribed home infusion therapy regimen; or • services from an in-network home infusion therapy Provider. Health plans may exclude coverage for a Provider to administer home infusion therapy when the patient or an alternate caregiver can be trained to do so.	Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 26.
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				Diagnosis and Medically Necessary treatment of musculoskeletal disorders that affect any bone or joint in the face, neck, or head and are the result of accident, trauma, congenital defect, developmental defect, or pathology is covered to the extent required by 8 V.S.A. § 4089g. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 10.
Nutritional Counseling	Yes	Covered	No				Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 20.
Reconstructive Surgery	Yes	Covered	No				Reconstructive Procedures are covered when Medically Necessary unless expressly excluded. For purposes of this EHB Benchmark, “Reconstructive Procedures” are Medically Necessary procedures to correct gross deformities with physiological and functional impairments attributable to congenital defects, injury (including injuries occurring at birth), disease, or other health conditions (including gender dysphoria). “Reconstructive Procedures” include reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, following Medically Necessary removal of all or part of a breast or breasts. Please see State of Vermont Essential Health Benefits Benchmark Plan, pgs. 9-10.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Gender Affirming Care	Yes	Covered	No				Medically Necessary treatment for gender dysphoria and related health conditions is covered to the extent required by 8 V.S.A. § 4724 and Insurance Bulletin 174. Please see State of Vermont Essential Health Benefits Benchmark Plan, pg. 13.

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 (Expires 02/28/2024)**. The time required to complete this information collection is estimated to average **47 hours or 2,820 minutes per response for States. For Form 1, the estimate is 4 hours. For Form 2, the estimate is 19 hours. For Form 3, the estimate is 12 hours. For Form 4, the estimate is 12 hours.** 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.

******CMS Disclosure******
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Ken Buerger at Ken.Buerger@cms.hhs.gov.