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

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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				Page 30
Specialist Visit	Yes	Covered	No				Page 30
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				Page 30
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				Pages 28 and 35
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				Page 28
Hospice Services	Yes	Covered	No				Page 36; Hospice benefits are provided only for the treatment of Members diagnosed with a condition where there is a life expectancy of 6 months or less. Preauthorization is required.
Routine Dental Services (Adult)	No	Not Covered	No				Exclusions: pages 40-46
Infertility Treatment	No	Not Covered	No				Exclusions: pages 40-46
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				Exclusions: pages 40-46
Private-Duty Nursing	No	Not Covered	No				Exclusions: pages 40-46
Routine Eye Exam (Adult)	No	Not Covered	No				Exclusions: pages 40-46
Urgent Care Centers or Facilities	Yes	Covered	No				Page 30
Home Health Care Services	Yes	Covered	Yes	40	Visit(s) per Benefit Period	No Home Health Care benefits will be provided for: 1. Dietitian services; 2. Homemaker services; 3. Social worker services; 4. Maintenance Care; 5. Custodial Care; 6. Food or home delivered meals; or 7. Respite care.	Page 35; Covered Services include: 1. The professional services of an R.N., Licensed Vocational Nurse or L.P.N.; 2. Physical, Occupational or Speech Therapy; 3. Medical and surgical supplies; 4. Administration of prescribed drugs; 5. Oxygen and the administration of oxygen; and 6. Health aide services for a Member who is receiving covered Skilled Nursing Services or Therapy Services. A visit is considered up to 4 continuous hours.
Emergency Room Services	Yes	Covered	No				Page 30
Emergency Transportation/Ambulance	Yes	Covered	No				Page 35; Medically Appropriate and Necessary Ambulance Services to the nearest facility equipped to provide the required level of care, including transportation: from the home or site of an Emergency Medical Condition; between hospitals; and between a Hospital and Skilled Nursing Facility. Benefits for air transportation are available only when ground transportation is not Medically Appropriate and Necessary as determined by INSURER.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				Page 27
Inpatient Physician and Surgical Services	Yes	Covered	No				Page 28
Bariatric Surgery	Yes	Covered	Yes	1	Procedure(s) per Lifetime		Page 29; Surgery for morbid obesity after Prior Approval is received from INSURER. Covered Services must be received from a surgical facility approved by INSURER. Benefits are subject to a Lifetime Maximum of 1 operative procedure for morbid obesity per Consumer. No benefits are available for the repair or modification of any or all types of surgical morbid obesity procedures, except a Lifetime Maximum of 1 revision will be allowed per Consumer due to technical staple line failure. Benefits for all proposed surgical procedures for the treatment of complications resulting from any or all types of surgical morbid obesity procedures are available only when Prior Approval is received from INSURER.
Cosmetic Surgery	No	Not Covered	No				Pages 28 and 42; Cosmetic surgery will not qualify as reconstructive surgery when performed for the treatment of a psychological or psychiatric condition.
Skilled Nursing Facility	Yes	Covered	Yes	30	Day(s) per Benefit Period	Benefits are not available for Maintenance Care or Custodial Care.	Page 35
Prenatal and Postnatal Care	Yes	Covered	No				Page 33
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				Page 32
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			Excludes coverage of "Counseling or therapy services, Including bereavement, codependency, marital, family, sex or interpersonal relationships."	Page 34; For psychiatric services, prior authorization required for inpatient, residential treatment, and partial hospitalization.
Mental/Behavioral Health Inpatient Services	Yes	Covered	No			Excludes coverage of "Counseling or therapy services, Including bereavement, codependency, marital, family, sex or interpersonal relationships."	Page 34; For psychiatric services, prior authorization required for inpatient, residential treatment, and partial hospitalization.
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			No benefits are available for non-inpatient pharmacological detoxification management, Including Outpatient, Intensive Outpatient Program (IOP), Partial Hospitalization program (PHP) setting, or Residential Treatment detoxification.	Page 35; Outpatient benefits include diagnostic, evaluation and treatment services provided by a Physician, Licensed Clinical Psychologist or Licensed Addiction Counselor, including for gambling addiction.
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			No benefits for residential treatments for psych or SUD for ages 21 and over.	Page 34; Benefits are available for the inpatient treatment of substance abuse, including medically managed inpatient detoxification, medically monitored inpatient detoxification, medically managed intensive inpatient treatment or medically monitored intensive inpatient treatment, when provided at an appropriately licensed and credentialed Substance Abuse Facility. Benefits available for residential treatment for members under age 21. Benefits available for partial hospitalization. Preauthorization is required. For SUD, PA required for inpatient, residential, partial hospitalization, and intensive outpatient.
Generic Drugs	Yes	Covered	No				Page 25 and 38
Preferred Brand Drugs	Yes	Covered	No				Page 25 and 38
Non-Preferred Brand Drugs	Yes	Covered	No				Page 25 and 38
Specialty Drugs	Yes	Covered	No				Page 25; Specialty Drugs are subject to a dispensing limit of a 30-day supply.
Outpatient Rehabilitation Services	Yes	Covered	Yes	30	Visit(s) per Benefit Period		Page 31 and 32; Rehabilitative Services: therapies that are designed to restore function following a surgery or medical procedure, injury or illness. 30-visit limit is for each of PT, OT, and ST, rehab and hab combined. Benefits are not available for Maintenance Care.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Benefit Period	Benefits are not available for Maintenance Care.	Page 32; "Habilitative Physical Therapy, Occupational Therapy or Speech Therapy is care provided for conditions which have limited the normal age appropriate motor, sensory or communication development. To be considered habilitative, functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Member's maximum potential. Functional skills are defined as essential activities of daily life common to all Members such as dressing, feeding, swallowing, mobility, transfers, fine motor skills, age appropriate activities and communication. Problems such as hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance, an orthopedic impairment, autism spectrum disorders, traumatic brain injury, deaf blindness, or multiple disabilities may warrant Habilitative Therapies. Measurable progress emphasizes accomplishment of functional skills and independence in the context of the Member's potential ability as specified within a care plan or treatment goals. Benefits are subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1, for each type of therapy under an individual medical plan (IMP) developed for each Member."
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Benefit Period		Page 32; Chiropractic services provided on an inpatient or outpatient basis when Medically Appropriate and Necessary and within the scope of licensure and practice of a Chiropractor, to the extent services would be covered if provided by a Physician.
Durable Medical Equipment	Yes	Covered	No			No benefits are available for motorized equipment, except wheelchairs when Prior Approval is received from INSURER. No benefits are available for batteries required for Home Medical Equipment, except for wheelchair batteries. Covered Services include replacement and repairs when Medically Appropriate and Necessary. Benefits will not be provided for any Home Medical Equipment required for leisure or recreational activity or to allow a Member to participate in a sport activity.	Pages 36 and 37
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years		Page 42: Communication aids or devices to create, replace or augment communication abilities, Including hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication EXCEPT coverage shall be provided for one hearing aid per hearing-impaired ear every 36 months or more often if there is a significant change in the insured's hearing status as determined by a licensed physician or audiologist. Hearing loss must be documents by a licensed physician or audiologist. Hearing aids must be purchased from a licensed audiologist.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				Pages 6, 10, 27, 30 as defined under Diagnostic Services; Coverage for position emission tomography scans for an insured who has a prostate cancer diagnosis, including an insured who is in remission or who is cured, which would include at least two different types of position emission tomography scans upon initial diagnosis if requested by a physician, and one position emission tomography scan every 6 months for the life of the insured.
Preventive Care/Screening/Immunization	Yes	Covered	No				Page 31; Preventive screening services for Members age 6 and older according to A or B Recommendations of the U.S. Preventive Services Task Force and issued by the Health Resources and Services Administration.
Routine Foot Care	No	Not Covered	No				Exclusions: pages 40-46
Acupuncture	No	Not Covered	No				Exclusions: pages 40-46
Weight Loss Programs	No	Not Covered	No				Exclusions: pages 40-46
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Benefit Period		Page 37
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Benefit Period	The tinting of lenses and ultraviolet lenses for eyeglasses or contact lenses is not covered.	Page 37; Frames are limited to one every other benefit period. Lenses are limited to one pair per benefit period.
Dental Check-Up for Children	Yes	Covered	Yes	2	Exam(s) per Benefit Period		Page 37
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Year	Benefits are not available for Maintenance Care.	Page 32; Rehabilitative Services: therapies that are designed to restore function following a surgery or medical procedure, injury or illness. Limit is combined for rehabilitation and habilitation services.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Year		Page 31; Rehabilitative Services: therapies that are designed to restore function following a surgery or medical procedure, injury or illness. 30-visit limit is for each of PT, OT, and ST, rehab and hab combined. Benefits are not available for Maintenance Care.
Well Baby Visits and Care	Yes	Covered	No				Page 31; Well Child Care to the Member's 6th birthday, 100% of Allowed Charge. Deductible Amount is waived. For baby includes 7 visits for Members from birth through 12 months.
Laboratory Outpatient and Professional Services	Yes	Covered	No				Page 30
X-rays and Diagnostic Imaging	Yes	Covered	No				Page 30
Basic Dental Care - Child	Yes	Covered	No				Page 37
Orthodontia - Child	Yes	Covered	Yes	1	Treatment(s) per Lifetime		Page 37; Only for "the treatment of improper alignment of biting or chewing surfaces of upper and lower teeth through the installation of orthodontic appliances."
Major Dental Care - Child	Yes	Covered	No				Page 37
Basic Dental Care - Adult	No	Not Covered	No				Exclusions: pages 40-46
Orthodontia - Adult	No	Not Covered	No				Exclusions: pages 40-46
Major Dental Care – Adult	Yes	Covered	No			Routine or chronic dental service not covered	Pages 21 and 30; Coverage for diagnosis and treatment of periodontal disease in acute or chronic disease state if recommended by a board-certified medical practitioner based on health-related impacts or on further deterioration in disease state due to gum disease.
Abortion for Which Public Funding is Prohibited	No	Not Covered	No				Exclusions: pages 40-46; Excludes "Abortions, except for those necessary to prevent the death of the woman. No benefits are available for removal of all or part of a multiple gestation."
Transplant	Yes	Covered	Yes	1	Exam(s) per Transplant	Benefits are not available under this Benefit Plan if the Member is the donor for transplant services. Benefits are not available for artificial organs, donor search services or organ procurement if the organ or tissue is not donated.	Page 29; One evaluation is allowed per transplant procedure. Services must be performed at a qualified transplant center.

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Accidental Dental	Yes	Covered	No			Injury as a result of chewing or biting is not considered an accidental injury.	Page 30; An accidental injury is defined as an injury that is the result of an external force causing a specific impairment to the jaw, sound natural teeth, dentures, mouth or face. Covered Services must be initiated within 6 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by INSURER is in place.
Dialysis	Yes	Covered	No				Page 30
Allergy Testing	Yes	Covered	No			Excludes the following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.	Page 30; Benefit includes serum, direct skin testing and patch testing when ordered by a Professional Health Care Provider and performed in accordance with medical guidelines and criteria established by INSURER.
Chemotherapy	Yes	Covered	No				Page 30
Radiation	Yes	Covered	No				Page 30
Diabetes Education	Yes	Covered	No				Page 31
Prosthetic Devices	Yes	Covered	No			Maxillofacial prosthetics. Prosthetic Limbs or components intended only for cosmetic purposes or customized coverings for terminal devices. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a Member to participate in sport activities. Benefits are not available for dental appliances (except as listed in the Schedule of Benefits, Section 1), artificial organs or Prosthetic Appliances and Limbs intended only for cosmetic purposes.	Page 36; Prior Approval is required. Benefits are available for externally worn breast prostheses and surgical bras, including necessary replacements following mastectomy, subject to a Maximum Benefit Allowance of 2 external prostheses and 2 bras per Member per Benefit Period. For a double mastectomy, allow a Maximum Benefit Allowance of 4 external prostheses and 2 bras per Member per Benefit Period.
Infusion Therapy	Yes	Covered	No				Page 30; Covered Services include the provision of nutrients, antibiotics, and other drugs and fluids intravenously, through a feeding tube, or by inhalation; all Medically Appropriate and Necessary supplies; and therapeutic drugs or other substances. Covered Services also include Medically Appropriate and Necessary enteral feedings when such feedings are the sole source of nutrition for a Member.
Treatment for Temporomandibular Joint Disorders	Yes	Covered	Yes	2	Treatment(s) per Lifetime	No benefits will be provided for Orthodontic services (except as determined Medically Appropriate and Necessary) or Osseo integrated implant surgery or related services performed for the treatment of temporomandibular or craniomandibular joint disorder(s).	Page 30; Benefits are subject to a Lifetime Maximum of 2 surgical procedures per Member and a Maximum Benefit Allowance of 1 splint per Member per Benefit Period.
Nutritional Counseling	Yes	Covered	Yes	12	Visit(s) per Benefit Period	Excluded: Nutritional counseling for the control of dental disease, oral hygiene instruction and personal hygiene and convenience items.	Page 31; Coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes-related diagnosis, or a chronic illness or condition that could be managed through nutritional or weight loss programs, up to 12 sessions every policy year, if prescribed by the insured's physician. This would also include coverage for the use of GLP1 and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome or morbid obesity.
Reconstructive Surgery	Yes	Covered	No				Page 28; Reconstructive surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.