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				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	Yes	20	Visit(s) per Year		Coverage is limited to 20 visit/calendar year for acupuncture and chiropractor.
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				Diagnosis and medically indicated treatments for physical conditions causing infertility
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				
Home Health Care Services	Yes	Covered	Yes	100	Day(s) per Year		
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				Bariatric surgery is Covered for patients with a Body Mass Index (BMII) 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				
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year		
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				
Habilitation Services	Yes	Covered	No				Physical, Occupational and Speech Therapy and Autism Spectrum disorder diagnosis and treatment
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year		
Durable Medical Equipment	Yes	Covered	No				
Hearing Aids	Yes	Covered	Yes	1			1 per ear every 3 years
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				
Preventive Care/Screening/Immunization	Yes	Covered	No				Shall include artery calcification testing for the diagnosis of heart disease
Routine Foot Care	No	Not Covered	No				
Acupuncture	Yes	Covered	Yes	20	Visit(s) per Year		
Weight Loss Programs	Yes	Covered	No				Weight loss drugs only covered if Medically Necessary treatment for morbid obesity and obesity.
Routine Eye Exam for Children	Yes	Covered	No				
Eye Glasses for Children	Yes	Covered	No				
Dental Check-Up for Children	Yes	Covered	No				
Rehabilitative Speech Therapy	Yes	Covered	No				
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	No				
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				
Major Dental Care - Child	Yes	Covered	No				
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No				Elective abortions up to 24 weeks.
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				Benefits are available when received from a Practitioner/Provider who is approved to provide diabetes education.
Prosthetic Devices	Yes	Covered	No				Covered when medically necessary
Infusion Therapy	Yes	Covered	No				
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				
Nutritional Counseling	Yes	Covered	No				Nutritional support Covered only when prescribed by an In-Network Practitioner/Provider and administered by enteral tube feedings.
Reconstructive Surgery	Yes	Covered	No				Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be Covered if performed for the correction of functional disorders.