

	The State's EHB-benchmark Plan's Benefits and Limits						OMB Control Number: 0938-1174 Expiration Date: 02/28/2024
<p>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.</p>							
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				pg. 15
Specialist Visit	Yes	Covered	No				pg. 15
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				pg. 15, Covered only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this plan, and when benefits would be payable if the services were provided by a physician.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				pg. 5, 10
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				pg. 10
Hospice Services	Yes	Covered	Yes	6	Month(s) per Lifetime	Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions, Over-the-counter drugs, solutions and nutritional supplements, Drugs and solutions received while you're an inpatient, except for covered inpatient hospice care, Services provided to someone other than the ill or injured member, Services of family members or volunteers, Services, supplies or providers not in the written plan of care or not named as covered in this benefit, Custodial care, except for hospice care services, Non-medical services, such as spiritual, bereavement, legal or financial counseling, Normal living expenses, such as food, clothing, and household supplies; housekeeping services except for those of a home health aide as prescribed by the plan of care; and transportation services, Dietary assistance, such as "meals on Wheels," or nutritional guidance.	pg. 9, Inpatient hospice care up to a maximum of 10 days. Respite care, up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	No	Not Covered	No				
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				p. 15
Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year	Services, supplies or providers not in the written plan of care or not named as covered benefit. Services provided to someone other than the ill or injured member. Custodial care, except for hospice care services. Non-medical services. Normal living expenses; and transportation services. Dietary assistance, such as "Meals on Wheels," or nutritional guidance.	pg. 9, 130 visits per member each calendar year applies to home visits of a home health care provider or one or more: registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers; and a person with a master's degree in social work.
Emergency Room Services	Yes	Covered	No			Treatment of Substance Use Disorder, except treatment of medically necessary detoxification services provided on same basis as any other emergency medical condition.	pg. 8
Emergency Transportation/Ambulance	Yes	Covered	No			Air and Ground transportation: Services that aren't sudden and life-endangering, Transport by taxi, bus, private car or rental car, Meals and lodging.	pg. 4, Air and Ground transportation benefit is limited to medical emergency. Ambulance services is separate benefit, covers both medical emergency transport and non-emergent transport.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless the medical condition makes inpatient care medically necessary. Any days of inpatient care that exceed the length of stay that is medically necessary to treat the condition.	pg. 10
Inpatient Physician and Surgical Services	Yes	Covered	No				pg. 10
Bariatric Surgery	No	Not Covered	No				

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Cosmetic Surgery	No	Not Covered	No				Exceptions to no coverage for cosmetic surgery: Repair of a defect that's the direct result of an accidental injury. Repair of a dependent child's congenital anomaly. Reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit. Correction of functional disorders (not including removal of excess skin and/or fat related to weight loss surgery or the use of obesity drugs), upon our review and approval.
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year		pg. 17
Prenatal and Postnatal Care	Yes	Covered	No				pg. 14
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				pg. 14
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			Dementia and sleep disorders. Biofeedback services for psychiatric conditions other than generalized anxiety disorder. Family and marital counseling, and family and marital psychotherapy, except when medically necessary to treat the diagnosed psychiatric condition or conditions of a member. Therapeutic or group homes, foster homes, nursing homes, boarding homes or schools, military academies, and child welfare facilities. Telephonic services, except for crisis/emergency evaluations, or when the member is temporarily confined to bed for medical reasons. Telehealth services that do not utilize real-time video or audio services. Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders. Treatment of sexual dysfunctions, such as impotence. All medical services provided in preparation for or after gender reassignment surgery, also	pg. 15
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				pg. 10, 15
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential Substance Use Disorder treatment. Residential detoxification.	pg. 15
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential Substance Use Disorder treatment. Residential detoxification.	pg. 10, 15
Generic Drugs	Yes	Covered	No				pg. 19-20
Preferred Brand Drugs	Yes	Covered	No				pg. 19-20
Non-Preferred Brand Drugs	Yes	Covered	No				pg. 19-20
Specialty Drugs	Yes	Covered	No				pg. 19-20
Outpatient Rehabilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Recreational, vocational or educational therapy. Exercise or maintenance-level programs. Social or cultural therapy. Treatment that isn't actively engaged in by the ill, injured or impaired member. Gym or swim therapy. Custodial care. Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made the rehabilitation necessary.	pg. 16-17, A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the visit maximum. Multiple therapy sessions on the same day will be counted as 1 visit, unless provided by different health care providers.

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Habilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof.	pg. 5, Habilitative services is only covered in the context of autism spectrum disorders services, including ABA, counseling and treatment programs necessary to develop, maintain, or restore the functioning of an individual.
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year		pg. 17
Durable Medical Equipment	Yes	Covered	No			Supplies or equipment not primarily intended for medical use, Special or extra-cost convenience features, exercise equipment or weights, orthopedic appliances for use in sports, recreation or similar activities, penile prostheses, whirlpools, sauna baths, massage devices, structural modifications to home or vehicle.	pg. 11-12
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years		pg. 9, 1 per ear every 3 years
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No			Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy, Allergy Testing, Covered inpatient diagnostic services furnished and billed by inpatient facility, covered outpatient diagnostic services billed by outpatient facility or emergency room and received in combination with other hospital or emergency room services, services relating to testing, diagnosis, or treatment of infertility, mammography services.	pg. 7-8
Preventive Care/Screening/Immunization	Yes	Covered	No				pg. 14-15
Routine Foot Care	Yes	Covered	No				pg. 15
Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year		pg. 4, Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition.
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				pg. 14, Appendix C
Eye Glasses for Children	Yes	Covered	No				pg. 14, Appendix C
Dental Check-Up for Children	Yes	Covered	No				pg. 7, Appendix B
Rehabilitative Speech Therapy	Yes	Covered	Yes	45	Visit(s) per Year		pg. 16-17, Visit limit for physical, speech, and occupational therapy services combined.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	45	Visit(s) per Year		pg. 16-17, Visit limit for physical, speech, and occupational therapy services combined.
Well Baby Visits and Care	Yes	Covered	No				pg. 14
Laboratory Outpatient and Professional Services	Yes	Covered	No				pg. 7-8
X-rays and Diagnostic Imaging	Yes	Covered	No				pg. 7-8
Basic Dental Care - Child	Yes	Covered	No				pg. 7, Appendix B
Orthodontia - Child	Yes	Covered	No				pg. 7, Appendix B
Major Dental Care - Child	Yes	Covered	No				pg. 7, Appendix B
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				pg. 14
Transplant	Yes	Covered	No			Organ, bone marrow and stem cell transplants, including any direct or indirect complications and after effects thereof, except as specifically stated under the Transplants benefit. Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit. Non-human or mechanical organs, unless they aren't "experimental or investigational services." Transplants or related services from a provider not approved by us. Services that will be paid by any government foundation or charitable grant. This includes services performed on potential or actual living donors or recipients and on cadavers. Planned blood storage for more than 12 months for possible future use.	pg. 18, The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are: Heart, Heart/double lung, single lung, Double lung, Liver, Kidney, Pancreas, Pancreas with kidney, Bone marrow (autologous and allogenic), Stem cell (autologous and allogeneic).
Accidental Dental	Yes	Covered	No				pg. 7
Dialysis	Yes	Covered	No				pg. 15
Allergy Testing	Yes	Covered	No				pg. 15
Chemotherapy	Yes	Covered	No				pg. 15, 29
Radiation	Yes	Covered	No				pg. 15
Diabetes Education	Yes	Covered	No				pg. 8
Prosthetic Devices	Yes	Covered	No				pg. 11, Benefit limited to initial purchase of prosthetic; does not cover replacement unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

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Infusion Therapy	Yes	Covered	No			Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for drugs and solutions. Over-the-counter drugs, solutions and nutritional supplements. Drugs and solutions received while you're an inpatient in a hospital or other medical facility.	pg. 10
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				pg. 19
Nutritional Counseling	Yes	Covered	No			"Nutritional therapy services that meet the federal guidelines designated as preventive care will be subject to applicable frequency limits."	pg. 13
Reconstructive Surgery	Yes	Covered	No				pg. 11, Breast reconstruction allowed.
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