



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

OMB Control Number: 0938-1174
Expiration Date: 11/30/2027

Instructions: All fields in columns B, C, and D 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				pg. 9
Specialist Visit	Yes	Covered	No				pg. 9
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				pg 9-10
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				pg. 9
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				pg. 9
Hospice Services	Yes	Covered	No			If you elect to receive hospice care, you will not receive additional benefits for the terminal illness	pg. 12-13, Life expectancy < 6 months
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Covered	No			a. Services to reverse voluntary, surgically induced infertility. b. All services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such services, and donor semen and donor eggs used for such services, such as, but not limited to in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.	pg. 9, The following services are covered, including X-ray and laboratory procedures: (a) Services for diagnosis and treatment of involuntary infertility; and (b) artificial insemination, except for donor semen, donor eggs and Services related to their procurement and storage.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	No				pg. 13, For hospital inpatient care, private duty nursing covered when a Plan Physician determines it is Medically Necessary.
Routine Eye Exam (Adult)	No	Covered	No			a. Eyeglass lenses and frames. b. Contact lenses. c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary. d. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy and similar procedures). e. Orthoptic (eye training) therapy.	pg. 33, Wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses are covered. Also covered are professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition. Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.
Urgent Care Centers or Facilities	Yes	Covered	No				pg. 12
Home Health Care Services	Yes	Covered	Yes	28	Hour(s) per Week	a. Custodial care. b. Homemaker Services. c. Care that the health plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.	pg. 8-9, Skilled nursing care, home health aide services and medical social Services are covered: a. only on a Part-Time Care or Intermittent Care basis; and b. only within our Service Area; and c. only if you are confined to your home; and d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Health Plan may approve additional time up to 35 hours per week but less than eight (8) hours per day on a case-by-case basis.
Emergency Room Services	Yes	Covered	No				pg. 10-12
Emergency Transportation/Ambulance	Yes	Covered	No			Transportation by other than a licensed ambulance.	pg. 12
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			(A) Dental services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by State Law, (B) Cosmetic surgery related to bariatric surgery.	pg. 13-14
Inpatient Physician and Surgical Services	Yes	Covered	No				pg. 13-14
Bariatric Surgery	Yes	Covered	No				pg. 12, You must meet health plan's criteria to be eligible for coverage.
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	100	Day(s) per Year	Custodial Care.	pg. 14-15, The following services are covered: a. Room and board. b. Nursing care. c. Medical social services. d. Medical and biological supplies. e. Blood, blood products and their administration.
Prenatal and Postnatal Care	Yes	Covered	No				pg. 9
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				pg.13
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			a. Evaluations for purposes other than mental health treatment; b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder; c. Mental health services ordered by a court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such services to be Medically Necessary; d. Court-ordered testing and testing for ability, aptitude, intelligence or interest; e. Services which are custodial or residential in nature.	pg. 21-22, Covered are: diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling. Visits for the purpose of monitoring drug therapy are covered. Psychological testing as part of diagnostic evaluation is covered. Mental Health Wellness Exam
Mental/Behavioral Health Inpatient Services	Yes	Covered	No			a. Evaluations for purposes other than mental health treatment; b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder; c. Mental health services ordered by a court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such services to be Medically Necessary; d. Court-ordered testing and testing for ability, aptitude, intelligence or interest; e. Services which are custodial or residential in nature.	pg. 21-22, Covered are psychiatric hospitalization in a facility designated by Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			Court-ordered treatment that exceeds the scope of this health benefit plan are not covered.	pg. 20-21, Outpatient rehabilitative services for the treatment of alcohol and drug dependency are covered when referred by a Plan Physician.
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			Court-ordered treatment that exceeds the scope of this health benefit plan are not covered.	pg. 20-21, Services are covered for the medical management of withdrawal symptoms. Medical services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Generic Drugs	Yes	Covered	No			a. Drugs for which a prescription is not required by law. b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages. c. Drugs and injections for the treatment of sexual dysfunction. d. Any packaging except the dispensing pharmacy's standard packaging. e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions. f. Drugs or injections for treatment of involuntary infertility. g. Drugs to shorten the length of the common cold. h. Drugs to enhance athletic performance. i. Drugs for the treatment of weight control. j. Drugs available over the counter and by prescription for the same strength. k. Unless approved by Health Plan, drugs: i. Not approved by the FDA; and ii. Not in general use as of March 1 of the year prior to your effective date or last renewal. l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. m. Prescription drugs necessary for Services excluded in the health plan Evidence of Coverage or Membership Agreement.	pg. 24
Preferred Brand Drugs	Yes	Covered	No			a. Drugs for which a prescription is not required by law. b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages. c. Drugs and injections for the treatment of sexual dysfunction. d. Any packaging except the dispensing pharmacy's standard packaging. e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions. f. Drugs or injections for treatment of involuntary infertility. g. Drugs to shorten the length of the common cold. h. Drugs to enhance athletic performance. i. Drugs for the treatment of weight control. j. Drugs available over the counter and by prescription for the same strength. k. Unless approved by Health Plan, drugs: i. Not approved by the FDA; and ii. Not in general use as of March 1 of the year prior to your effective date or last renewal. l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. m. Prescription drugs necessary for Services excluded in the health plan Evidence of Coverage or Membership Agreement.	pg. 23-26
Non-Preferred Brand Drugs	Yes	Covered	No			a. Drugs for which a prescription is not required by law. b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages. c. Drugs and injections for the treatment of sexual dysfunction. d. Any packaging except the dispensing pharmacy's standard packaging. e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions. f. Drugs or injections for treatment of involuntary infertility. g. Drugs to shorten the length of the common cold. h. Drugs to enhance athletic performance. i. Drugs for the treatment of weight control. j. Drugs available over the counter and by prescription for the same strength. k. Unless approved by Health Plan, drugs: i. Not approved by the FDA; and ii. Not in general use as of March 1 of the year prior to your effective date or last renewal. l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. m. Prescription drugs necessary for Services excluded in the health plan Evidence of Coverage or Membership Agreement.	pg. 23-26
Specialty Drugs	Yes	Covered	No			a. Drugs for which a prescription is not required by law. b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages. c. Drugs and injections for the treatment of sexual dysfunction. d. Any packaging except the dispensing pharmacy's standard packaging. e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions. f. Drugs or injections for treatment of involuntary infertility. g. Drugs to shorten the length of the common cold. h. Drugs to enhance athletic performance. i. Drugs for the treatment of weight control. j. Drugs available over the counter and by prescription for the same strength. k. Unless approved by Health Plan, drugs: i. Not approved by the FDA; and ii. Not in general use as of March 1 of the year prior to your effective date or last renewal. l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. m. Prescription drugs necessary for Services excluded in the health plan Evidence of Coverage or Membership Agreement.	pg. 24
Outpatient Rehabilitation Services	Yes	Covered	Yes	20	Visit(s) per Year		pg. 29
Habilitation Services	Yes	Covered	Yes	20	Visit(s) per Year		pg. 27-28, 20 visit limit per each therapy for physical therapy, occupational therapy, and speech therapy for habilitation services. Note: Habilitation services must be offered in parity with, and in addition to, rehabilitative services for physical therapy, occupational therapy, and speech therapy. Habilitative services are cumulative, such that coverage must include, at a minimum, no less than 60 visits for habilitative services (20 visits for PT, 20 visits for OT, and 20 visits for ST) per calendar year.

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Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year	a. Hypnotherapy. b. Behavior training. c. Sleep therapy. d. Weight loss programs. e. Services not related to the treatment of the musculoskeletal system. f. Vocational rehabilitation Services. g. Thermography. h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances. i. Transportation costs. This includes local ambulance charges. j. Prescription drugs, vitamins, minerals, food supplements or other similar products. k. Educational programs. l. Non-medical self-care or self-help training. m. All diagnostic testing related to these excluded Services. n. MRI and/or other types of diagnostic radiology. o. Physical or massage therapy that is not a part of the chiropractic treatment. p. Durable medical equipment (DME) and/or supplies for use in the home.	pg. 7, Coverage includes: a. Evaluation; b. Lab Services and X-rays required for chiropractic Services; and c. Treatment of musculoskeletal disorders.
Durable Medical Equipment	Yes	Covered	No			a. All other DME not described in coverage. b. Replacement of lost equipment. c. Repair, adjustments or replacements necessitated by misuse. d. More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.	pg. 27, Coverage is limited to the standard item of DME, prosthetic device or orthotic device that adequately meets the Member's medical needs.
Hearing Aids	Yes	Covered	No				pg. 31-32 and 37-38
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				pg. 30-31
Preventive Care/Screening/Immunization	Yes	Covered	No				pg. 32-33
Routine Foot Care	No	Covered	No				pg. 41, Routine foot care Services are covered when Medically Necessary.
Acupuncture	Yes	Covered	Yes		6 Visit(s) per Benefit Period		pg. 6
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				pg. 33-34
Eye Glasses for Children	Yes	Covered	Yes		1 Item(s) per 2 Years	Exclusion: Replacement of lost or broken lenses or frames.	pg. 37, 1 pair every 24 months includes the frames and lenses or contact lenses.
Dental Check-Up for Children	Yes	Covered	No				pg. 36-37
Rehabilitative Speech Therapy	Yes	Covered	Yes		20 Visit(s) per Year	Speech Therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems. Long-term rehabilitation, not including treatment	pg. 29-30, Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature. Covered if, in the judgement of a Plan Physician, significant improvement is achievable within a two-month period.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes		20 Visit(s) per Year		pg. 29-30, Covered if, in the judgement of a Plan Physician, significant improvement is achievable within a two month period. 60-day limit for inpatient rehab. Rehabilitative Occupational and Physical therapy each have 20 visit limits per year.
Well Baby Visits and Care	Yes	Covered	No				pg. 33
Laboratory Outpatient and Professional Services	Yes	Covered	No				pg. 30-31
X-rays and Diagnostic Imaging	Yes	Covered	No			Testing of a Member for a non-Member's use and/or benefit. Testing of a non-Member for a Member's use and/or benefit.	pg. 30-31
Basic Dental Care - Child	Yes	Covered	No				pg. 36-37, Diagnostic and Preventive Limitations 1. Prophylaxis (cleaning) is a benefit only ONCE in a 12 month period. 2. Oral evaluations (exams) are a benefit twice in a 12 month period. 3. Topical fluoride application is a benefit twice in a 12 month period. 4. Bitewing x-rays are a benefit only ONCE in a 12 month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months. 5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth. 6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations. 7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application. 8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
Orthodontia - Child	No	Not Covered	No				
Major Dental Care - Child	Yes	Covered	No				pg. 36-37, Diagnostic and Preventive Limitations 1. Prophylaxis (cleaning) is a benefit only ONCE in a 12 month period. 2. Oral evaluations (exams) are a benefit twice in a 12 month period. 3. Topical fluoride application is a benefit twice in a 12 month period. 4. Bitewing x-rays are a benefit only ONCE in a 12 month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months. 5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth. 6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations. 7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application. 8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
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	Yes	Covered	No				pg. 6, Abortion and any related services, drugs, or supplies are covered.

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Transplant	Yes	Covered	No			a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded. b. Non-human and artificial organs and their implantation are excluded. c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria. d. Travel and lodging expenses are excluded, except that in some situations, when the health plan or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the Transplant Administrative Offices.	pg. 15-16, Transplants are covered on a LIMITED basis as follows: a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants. b. Bone marrow transplants (autologous stem cell or allogeneic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome. c. If all medical criteria developed by the health plan are met, we cover: stem cell rescue; and transplants of organs, tissue or bone marrow.
Accidental Dental	No	Not Covered	No				
Dialysis	Yes	Covered	No				pg. 7-8, Dialysis services related to acute renal failure and end-stage renal disease are covered if the following criteria are met: 1. The Services are provided inside our Service Area; and 2. You meet all medical criteria developed by the health plan and by the facility providing the dialysis; and 3. The facility is certified by Medicare and contracts with the health plan; and 4. A Plan Physician provides a written referral for care at the facility.
Allergy Testing	Yes	Covered	No				pg. 31
Chemotherapy	Yes	Covered	No				pg. 26 and 31, "Orally administered anti-cancer medication" covered even under basic drug option.
Radiation	Yes	Covered	No				pg. 9, Radioactive materials used for therapeutic purposes.
Diabetes Education	Yes	Covered	No				pg. 32
Prosthetic Devices	Yes	Covered	No			Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.	pg. 28, The following prosthetic devices are covered, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan: i. Internally implanted devices for functional purposes, such as pacemakers and hip joints. ii. Prosthetic devices for Members who have had a mastectomy. The Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prosthesis will be provided when necessary. iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn Members when prescribed by a Plan Physician and obtained from sources designated by Health Plan. iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accord with this EOC. Including repairs and replacements, of such prosthetic devices.
Infusion Therapy	Yes	Covered	No				pg. 31
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				pg. 10, TMJ is listed in exclusions but the following Services for TMJ may be covered if a Plan Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.
Nutritional Counseling	Yes	Covered	No				pg. 32
Reconstructive Surgery	Yes	Covered	No			Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. this includes cosmetic surgery related to bariatric surgery.	pg. 14, Reconstructive surgery is covered when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma (port wine stains) on the face and neck of Members 18 years and younger. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.
Gender Affirming Care	Yes	Covered	No				pg. 39-40, Medically-necessary gender-affirming care.

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