



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

OMB Control Number: 0938-1174
Expiration Date: 02/28/2027

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				P. 16 under "Office Visits"
Specialist Visit	Yes	Covered	No				P. 16 under "Office Visits"
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				P. 16 under "Office Visits"
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				P. 22, 36, & 43.
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				P. 26 under "Outpatient Surgical Procedures"
Hospice Services	Yes	Covered	Yes	180	Day(s) per Benefit Period		P. 8
Routine Dental Services (Adult)	No	Not Covered	No				N/A, not covered.
Infertility Treatment	Yes	Covered	No				P. 20
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				N/A, not covered.
Private-Duty Nursing	No	Not Covered	No				N/A, not covered.
Routine Eye Exam (Adult)	No	Not Covered	No				N/A, not covered.
Urgent Care Centers or Facilities	Yes	Covered	No				P. 27
Home Health Care Services	Yes	Covered	Yes	90	Visit(s) per Episode		P. 6-7. A new episode of care begins if the member does not receive Home Health Care for the same or a different condition for 60 consecutive days. Prior authorization is required
Emergency Room Services	Yes	Covered	No				P. 28
Emergency Transportation/Ambulance	Yes	Covered	No				P. 28
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				P. 8-9. Prior authorization is required except for emergency admissions and all maternity admissions. Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period.
Inpatient Physician and Surgical Services	Yes	Covered	No				P. 8, Including MH/SUD P.15
Bariatric Surgery	No	Not Covered	No				N/A, not covered.
Cosmetic Surgery	No	Not Covered	No				N/A, not covered.
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Benefit Period		P. 37. Member must require care on a daily basis, care must not be custodial, and care must only be provided on an inpatient basis. Prior authorization is required.

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Prenatal and Postnatal Care	Yes	Covered	No				P. 19-21
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				P. 19
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				P. 14-15
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				P. 14-15
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				P. 14-15
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				P. 14-15
Generic Drugs	Yes	Covered	No				P. 38
Preferred Brand Drugs	Yes	Covered	No				P. 38
Non-Preferred Brand Drugs	Yes	Covered	No				P. 38
Specialty Drugs	Yes	Covered	No				P. 38
Outpatient Rehabilitation Services	Yes	Covered	Yes	30	Visit(s) per Episode		P. 21-22. A new episode of care begins if the member does not receive rehabilitation services for the same or a different condition for 60 consecutive days.
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Episode		P. 22. A new episode of care begins if the member does not receive habilitative services for the same or a different condition for 60 consecutive days.
Chiropractic Care	Yes	Covered	No			Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.	P. 22. Coverage is provided for medically necessary spinal manipulation, evaluation, and treatment for the musculoskeletal conditions of the spine when provided by a licensed chiropractor, doctor of osteopathy (D.O.), or other eligible practitioner.
Durable Medical Equipment	Yes	Covered	No				P. 11-12
Hearing Aids	No	Not Covered	No				Not covered, exclusion cited on P. 49
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				P. 16
Preventive Care/Screening/Immunization	Yes	Covered	No				P. 16; Immunization 17
Routine Foot Care	No	Not Covered	No				N/A; not covered
Acupuncture	No	Not Covered	No				N/A; not covered
Weight Loss Programs	No	Not Covered	No				N/A; not covered
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Benefit Period		P. 34
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Benefit Period		P. 34-36 (spectacles)
Dental Check-Up for Children	Yes	Covered	Yes	2	Procedure(s) per Benefit Period		P. 29-31
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Episode		P. 21-22. A new episode of care begins if the member does not receive rehabilitation services for the same or a different condition for 60 consecutive days.

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Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Episode		P. 21-22. A new episode of care begins if the member does not receive rehabilitation services for the same or a different condition for 60 consecutive days.
Well Baby Visits and Care	Yes	Covered	No				P. 17 under "Well Child Care"
Laboratory Outpatient and Professional Services	Yes	Covered	No				P. 16
X-rays and Diagnostic Imaging	Yes	Covered	No				P. 16
Basic Dental Care - Child	Yes	Covered	No				P. 29-31
Orthodontia - Child	Yes	Covered	Yes	1	Treatment(s) per Lifetime		P. 33 Braces once per lifetime.
Major Dental Care - Child	Yes	Covered	No				P. 29-31
Basic Dental Care - Adult	No	Not Covered	No				N/A; not covered
Orthodontia - Adult	No	Not Covered	No				N/A; not covered
Major Dental Care – Adult	No	Not Covered	No				N/A; not covered
Abortion for Which Public Funding is Prohibited	Yes	Covered	No				P. 19
Transplant	Yes	Covered	No			Non-human organs and their implantation; hospital or professional charges related to any accidental injury or medical condition of the donor of the transplant material; charges related to transportation, lodging, and meals unless authorized or approved; services for a member who is an organ donor when the recipient is not a Member, and donor search services are not covered.	P. 22-23. Transplants and related services must be coordinated and prior authorization must be obtained. Prior authorization is not required for cornea transplants and kidney transplants.
Accidental Dental	Yes	Covered	No			Injuries to teeth that are not Sound Natural Teeth are not covered. Injuries as a result of biting or chewing are not covered.	P. 25. Only medically necessary dental services such as restoration of the tooth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury is covered.
Dialysis	Yes	Covered	No				P. 22
Allergy Testing	Yes	Covered	No				P. 21
Chemotherapy	Yes	Covered	No				P. 22-23
Radiation	Yes	Covered	No				P. 22-23
Diabetes Education	Yes	Covered	No				P. 25, under "Diabetes Equipment and Supplies, and Self-Management Training"
Prosthetic Devices	Yes	Covered	No			Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service are not covered.	P. 11
Infusion Therapy	Yes	Covered	No				P. 9 & 22.
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				P. 26
Nutritional Counseling	Yes	Covered	No				P. 18

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Reconstructive Surgery	Yes	Covered	No				P. 27. Surgical procedures must be medically necessary, as determined, and must be operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.

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