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	No				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	No				Respite care provided in a nursing facility subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days.
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	Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				
Home Health Care Services	Yes	Covered	No				
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	No	Not Covered	No				
Cosmetic Surgery	Yes	Covered	No				Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred unless medically necessary.
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	Yes	30	Visit(s) per Year		Visit limit does not apply to treatment of mental health conditions.
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Year		Visit limit does not apply to treatment of mental health conditions.
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year		
Durable Medical Equipment	Yes	Covered	No				$5,000 limit on non-Essential Health Benefit Durable Medical equipment.
Hearing Aids	Yes	Covered	Yes	2000	Dollar(s) per 2 Years		Covers hearing aids for members under 18 years of age and younger, or 25 years of age and younger if the member is enrolled in college.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	Yes	Covered	No				
Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year		
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				Supplemented with FEP BlueVision - High Option.
Eye Glasses for Children	Yes	Covered	No				Supplemented with FEP BlueVision - High Option.
Dental Check-Up for Children	Yes	Covered	No				Supplemented with OHP Plus.
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Year		30 visits per condition per calendar year. Visit limit does not apply to treatment of mental health conditions.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Year		Visit limit does not apply to treatment of mental health conditions.
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				Supplemented with OHP Plus.
Orthodontia - Child	Yes	Covered	No				Supplemented with OHP Plus.
Major Dental Care - Child	Yes	Covered	No				Supplemented with OHP Plus.
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	Not Covered	No				
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	Yes	3	Hour(s) per Year		Covers three hours of education per year if there is a significant change in condition or treatment; covers one diabetes self-management education program at the time of diagnosis.
Prosthetic Devices	Yes	Covered	No				
Infusion Therapy	Yes	Covered	No				
Treatment for Temporomandibular Joint Disorders	No	Not Covered	No				
Nutritional Counseling	Yes	Covered	Yes	5	Visit(s) per Lifetime		Visit limit does not apply to treatment of mental health conditions.
Reconstructive Surgery	Yes	Covered	No				Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred unless medically necessary.