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				P. 13-14 under "Physician's Office Services"
Specialist Visit	Yes	Covered	No				p. 13-14 under "Physician's Office Services", defined on p. 37 under "Specialist Physician"
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				p. 13 under "Physician Fees for Surgical and Medical Services"
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				p. 13 under "Physician Fees for Surgical and Medical Services"
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				p. 13 under "Physician Fees for Surgical and Medical Services"
Hospice Services	Yes	Covered	No				p. 9 under "Hospice Care" Benefits must be covered at level that is at least equal to Medicare benefits for both in and out of network
Routine Dental Services (Adult)	No	Not Covered	No				N/A, not covered.
Infertility Treatment	No	Not Covered	No			In vitro fertilization regardless of the reason for treatment.	p. 28 The exclusion does not apply to Coverage for Iatrogenic Infertility Preservation Services
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				N/A, not covered.
Private-Duty Nursing	Yes	Covered	Yes	250	Visit(s) per Year		p. 9 under "Home Health Care" One visit equals eight hours of skilled care services
Routine Eye Exam (Adult)	No	Not Covered	No				N/A, not covered.
Urgent Care Centers or Facilities	Yes	Covered	No				p. 20 under "Urgent Care Center Services"
Home Health Care Services	Yes	Covered	Yes	100	Visit(s) per Year		p. 9 under "Home Health Care" One visit equals at least four hours of skilled care services.
Emergency Room Services	Yes	Covered	No				p. 8 under "Emergency Medical Services - Outpatient" & p. 10 under "Hospital - Inpatient Stay"
Emergency Transportation/Ambulance	Yes	Covered	No				p. 3 under "Ambulance Services"
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				p. 10 under "Hospital - Inpatient Stay"
Inpatient Physician and Surgical Services	Yes	Covered	No				p. 10 under "Hospital - Inpatient Stay"
Bariatric Surgery	No	Not Covered	No				N/A, not covered.
Cosmetic Surgery	No	Not Covered	No				N/A, not covered.

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Skilled Nursing Facility	Yes	Covered	Yes	90	Day(s) per Year		p. 17-18 under "Skilled Nursing Facility/Inpatient Rehabilitation Facility Services" 90 days per year in a Skilled Nursing Facility. 60 days per year in an Inpatient Rehabilitation Facility.
Prenatal and Postnatal Care	Yes	Covered	No				p. 14 under "Pregnancy - Maternity Services"
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				p. 14 under "Pregnancy - Maternity Services"
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				p. 11 under "Mental Health Services"
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				p. 11 under "Mental Health Services"
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				p. 18-19 under "Substance Use Disorder Services"
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				p. 18-19 under "Substance Use Disorder Services"
Generic Drugs	Yes	Covered	No				p.39 under "Outpatient Prescription Drug Products"
Preferred Brand Drugs	Yes	Covered	No				p. 39 under "Outpatient Prescription Drug Products"
Non-Preferred Brand Drugs	Yes	Covered	No				p. 39 under "Outpatient Prescription Drug Products"
Specialty Drugs	Yes	Covered	No				p. 40 under "Specialty Prescription Drug Products"
Outpatient Rehabilitation Services	Yes	Covered	Yes	25	Visit(s) per Year		p. 16 under "Rehabilitative Services" Includes yearly limits: 25 PT visit, 25 OT visits. Visit limit does not apply to Speech Therapy.
Habilitation Services	Yes	Covered	Yes	25	Visit(s) per Year		p. 16-17 under "Habilitative Services" "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder. Includes yearly visit limits that are the same as the outpatient rehabilitation services limits: 25 PT visits; 25 OT visits. Visit limit does not apply to Speech Therapy.
Chiropractic Care	Yes	Covered	Yes	20	Treatment(s) per Year		p. 16 under "Rehabilitation Services" as "Manipulative Treatment". See also: definition of Manipulative Treatment on p. 35

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Durable Medical Equipment	Yes	Covered	No			Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Benefits are available for repairs and replacement, except that: Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect. Benefits are not available to replace lost or stolen items.	p. 7-8 under "Durable Medical Equipment"
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years	Benefits under this section do not include bone anchored hearing aids	p. 8-9 under "Hearing Aids" Benefits are limited to one hearing aid, per hearing impaired ear, every 36 months as required by Kentucky Insurance law.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				p. 10-11 under "Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine Outpatient"
Preventive Care/Screening/Immunization	Yes	Covered	No				p. 14-15 under "Preventative Care Services"
Routine Foot Care	No	Not Covered	No				N/A, not covered. This exclusion does not apply to preventive foot care for Covered Person with diabetes for which Benefits are provided.
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 Year		p. 51 under "Routine Vision Examination" & p. 52 under "Covered Benefits and Limitations"
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Year		p. 51-52 beginning under "Eyeglass Lenses" Benefits are also provided for the coverage of one pair of replacement eyeglasses every 12 months or repair of lenses and/or frames when medically necessary.
Dental Check-Up for Children	Yes	Covered	Yes	2	Visit(s) per Year		p. 45 under "Diagnostic Services"
Rehabilitative Speech Therapy	Yes	Covered	No				p. 16 under "Rehabilitation Services - Outpatient Therapy and Manipulative Treatment"
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	25	Visit(s) per Year		p. 16 under "Rehabilitation Services - Outpatient Therapy and Manipulative Treatment" 25 visits of physical therapy. 25 visits of occupational therapy.

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Well Baby Visits and Care	Yes	Covered	No				p. 14-15 under "Preventative Care Services"
Laboratory Outpatient and Professional Services	Yes	Covered	No				p. 10 under "Lab, X-Ray and Diagnostics - Outpatient"
X-rays and Diagnostic Imaging	Yes	Covered	No				p. 10 under "Lab, X-Ray and Diagnostics - Outpatient"
Basic Dental Care - Child	Yes	Covered	No				p. 45-46 under "Covered Benefits and Limitations"
Orthodontia - Child	Yes	Covered	No				p. 47 under "Medically Necessary Orthodontics".
Major Dental Care - Child	Yes	Covered	No				p. 45-46 under "Covered Benefits and Limitations"
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	No	Not Covered	No				N/A, not covered.
Transplant	Yes	Covered	No				p. 20 under "Transplantation Services"
Accidental Dental	Yes	Covered	No				p. 6 under "Dental Services - Accident Only"
Dialysis	Yes	Covered	No				p. 19-20 under "Theraputic Treatments - Outpatient"
Allergy Testing	Yes	Covered	No				p. 10 under "Lab, X-Ray and Diagnostics - Outpatient"
Chemotherapy	Yes	Covered	No				p. 19-20 under "Theraputic Treatments - Outpatient"
Radiation	Yes	Covered	No				p. 19-20 under "Theraputic Treatments - Outpatient"
Diabetes Education	Yes	Covered	No				p. 7 under "Diabetes Services"
Prosthetic Devices	Yes	Covered	No			Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.	p. 15-16 under "Prosthetic Devices"
Infusion Therapy	Yes	Covered	No				p. 19-20 under "Theraputic Treatments - Outpatient"
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				p. 19 under "Temporomandibular and Craniomandibular Joint Services" Examination, radiographs and applicable imaging studies and consultation.

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Nutritional Counseling	Yes	Covered	No				p. 7 under "Diabetes Self-Management and Training", p. 16-17 under "Habilitative Services", & p. 25 Nutritional Counseling Coverage is limited to nutritional education required for a disease in which patient self-management is an important component of treatment and there is a knowledge deficit regarding the disease which requires the intervention of a trained health professional; inborn error of metabolism; or genetic conditions.
Reconstructive Surgery	Yes	Covered	No			Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.	p. 16 under "Reconstructive Procedures" Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sicness, or Cogenital Anomaly.