Table 1. Coverage of Selected Benefits Within Federally Required EHB Categories

	Previous Benchmark	Largest Small Group Plans in the State			Largest State Employee Health Plans			Largest Federal Employee Health plans			Largest HMO in Commercial Market
	HMO Partners, Inc. Bluechoice Open Access POS	USAble Mutual Insurance Company; ABCBS PPO Gold 1000-2	HMO Partners, Inc. Gold Bluechoice Open Access POS	United Healthcare Insurance Company	ARBenefits Bronze	ARBenefits Silver	ARBenefits Gold	Blue Cross Blue Shield Standard Option PPO	Blue Cross Blue Shield Basic Option PPO	Government Employee Health Association, Inc. Standard Option PPO	BLUECHOICE OPEN ACCESS (Grandfathered)
	Link				Link (SBC)	Link (SBC)	Link (SBC)	Link	Link	Link	
Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Ambulatory Patient Services											
Primary care to treat an injury or illness	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions
Specialist visit	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitation / Exceptions	Covered; No Limitations / Exceptions
Other practitioner office visit	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Not Identified	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitation / Exceptions	Not Specified
Outpatient surgery facility fee (eg ambulatory Surgery center)	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitation / Exceptions	Covered; No Limitations / Exceptions
Outpatient surgery physician fee (eg ambulatory Surgery center)	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitation / Exceptions	Covered; No Limitations / Exceptions
Home health care	Covered; Nurse may not be related to member by blood or marriage, does not ordinarily reside in member home	Covered; Limited to 50 visits per Covered Person per calendar year	Covered; Limited to 50 visits per Member per Contract Year	Covered; limited to 60 visits per year One visit equals up to four hours of skilled care services	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Must be ordered by a physician, covers care for two hours per day when a registered nurse or licensed practical nurse provides the service	Covered; Must be ordered by a physician, covers care for two hours per day when a registered nurse or licensed practical nurse provides the service	Covered; 50 in-home visits per person per calendar year, not to exceed one visit up to two hours per day when provided by RN or LPN and ordered by attending physician and indicates the length of time for services and specific skills required	Covered; Nurse may not be related to member by blood or marriage, does not ordinarily reside in member home
Hospice service	Covered; For individuals with life expectancy of less than 6 months	Covered; Member must be diagnosed and certified by the attneding Physician as having a terminal illness with a life expectancy of six months or less	Covered; Member must be diagnosed and certified by the attneding Physician as having a terminal illness with a life expectancy of six months or less	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes homemaker services and home hospice care	Covered; Excludes homemaker services and home hospice care	Covered; Pay up to $15,000 for hospice care provided in an outpatient or inpatient setting	Covered; Member must be diagnosed and certified by the attending Physician as having a terminal illness with a life expectancy of six months or less
Skilled nursing care	Covered; 60 days per member per contract year, Must be admitted within 7 days of release from hospital	Covered; Prior Approval Required, Admission must be within seven days of release from an inpatient Hospital stay, Limited to 60 Days per Covered Person per calendar year	Covered; Must be authorized in advance by a Physician Admission must be within seven days of release from an inpatient Hospital stay, Limited to 60 days per Covered Person per contract year	Covered; Limited to 60 days per year in a Skilled Nursing Facility	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Only covered if Medicare Part A is the primary payor	Only covered if Medicare Part A is the primary payor	Covered; Inpatient confinement for the first 14 days following transfer from acute inpatient confinement when skilled care is still required Benefits limited to $700 per day	Covered; Admission must be within seven days of release from a Hospital
Emergency Services											

	Previous Benchmark	Largest Small Group Plans in the State			Largest State Employee Health Plans			Largest Federal Employee Health plans			Largest HMO in Commercial Market
	HMO Partners, Inc. Bluechoice Open Access POS	USAble Mutual Insurance Company; ABCBS PPO Gold 1000-2	HMO Partners, Inc. Gold Bluechoice Open Access POS	United Healthcare Insurance Company	ARBenefits Bronze	ARBenefits Silver	ARBenefits Gold	Blue Cross Blue Shield Standard Option PPO	Blue Cross Blue Shield Basic Option PPO	Government Employee Health Association, Inc. Standard Option PPO	BLUECHOICE OPEN ACCESS (Grandfathered)
	Link				Link (SBC)	Link (SBC)	Link (SBC)	Link	Link	Link	
Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Emergency room services	Covered; Initial services are provided within forty-eight (48) hours of the onset of the injury or illness	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Visits deemed non-emergency charged as hospital services / outpatient, the coinsurance / copayment will apply	Covered; Visits deemed non-emergency charged as hospital services / outpatient, the coinsurance / copayment will apply	Covered: Excludes emergency room professional charges for shift differentials	Covered: Excludes emergency room professional charges for shift differentials	Covered; No Limitations / Exceptions	Covered; Initial services are provided within forty-eight (48) hours of the onset of the injury or illness
Emergency medical transportation	Covered; Ground/Water: may not exceed $1,000 per trip; Air: may not exceed $5,000 per trip, limited to 1 trip per year	Covered; Ground-limited to $1,000/trip; Air-limited to $5,000/trip	Covered; Ground-limited to $1,000/trip; Air-limited to $5,000/trip	Covered; No Limitations / Exceptions	Covered; Limited benefit of $2000 per member per trip for ground ambulance	Covered; Limited benefit of $2000 per member per trip for ground ambulance	Covered; Limited benefit of $2000 per member per trip for ground ambulance	Covered; Excludes Wheelchair van services and gurney van services and Ambulance and any other modes of transportation to or from services	Covered; Excludes Wheelchair van services and gurney van services and Ambulance and any other modes of transportation to or from services	Covered; Local ambulance service within 100 miles to the first hospital where treated, also to next hospital if necessary treatment is unavailable Air Ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable	Covered; Ground/Water: may not exceed $1,000 per trip; Air: may not exceed $5,000 per trip, limited to 1 trip per year
Urgent care	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions
Hospitalization											
Hospital Facility fee (eg, hospital room)	Covered; No Limitations / Exceptions	Covered; Semi-private room	Covered; Semi-private room	Covered; No Limitations / Exceptions	If you select a private room, you are responsible for the difference in charges for a private room and semi-private room	If you select a private room, you are responsible for the difference in charges for a private room and semi-private room	If you select a private room, you are responsible for the difference in charges for a private room and semi-private room	Covered; semiprivate room only	Covered; semiprivate room only	Covered; semiprivate room only	Covered; No Limitations / Exceptions
Physician/surgeon fee	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions
Maternity and Newborn Care											
Prenatal and postnatal care	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Prenatal and postnatal outpatient care copayment required on first visit only	Covered; Prenatal and postnatal outpatient care copayment required on first visit only	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions

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	Link				Link (SBC)	Link (SBC)	Link (SBC)	Link	Link	Link	
Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Delivery and all inpatient services	Covered; Hospital stay for a newborn child for 48 hours following a vaginal delivery or 96 hours following a cesarean section	Covered; stay for at least 48 hours following a vaginal delivery or 96 hours following a cesarean section, Use of newborn nursery for up to 5 days or until the mother is discharged, whichever is the lesser period of time	Covered; stay for at least 48 hours following a vaginal delivery or 96 hours following a cesarean section, Use of newborn nursery for up to 5 days or until the mother is discharged, whichever is the lesser period of time	Covered; Must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery	Covered; Copayment applicable per admission; Benefits apply for at least 48 hours following a normal vaginal delivery or 96 hours following a caesarean section delivery	Covered; Copayment applicable per admission; Benefits apply for at least 48 hours following a normal vaginal delivery or 96 hours following a caesarean section delivery	Covered; Copayment applicable per admission; Benefits apply for at least 48 hours following a normal vaginal delivery or 96 hours following a caesarean section delivery	Covered; May remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery	Covered; May remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery	Covered; May remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery	Covered; Midwives not covered
Mental Health and Substance Use Disorder											
Mental/Behavioral health outpatient services	Covered; Supplemented; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Coverage of office visits and other outpatient treatment sessions, beyond the eighth session in a calendar year, except for medication management treatment sessions, is subject to prior approval from the company	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes Marital, family, educational, or other counseling or training services Testing and treatment for learning disabilities and mental retardation Applied behavior analysis and therapy Services performed by treatment centers, schools, halfway houses Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education Services performed or billed by residential therapeutic camps, light boxes, custodial or long term care	Covered; Excludes Marital, family, educational, or other counseling or training services Testing and treatment for learning disabilities and mental retardation Applied behavior analysis and therapy Services performed by treatment centers, schools, halfway houses Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education Services performed or billed by residential therapeutic camps, light boxes, custodial or long term care	Covered; semiprivate room only Excludes: services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems; Treatment for learning disabilities and mental retardation; telephone therapy, including therapy by remove video connection; travel time to the members home to conduct therapy; services rendered or billed by schools, or halfway houses or members of their staffs, marriage counseling, Applied behavior analysis	Covered; Coverage is limited to thirty (30) outpatient visits per year

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	Link				Link (SBC)	Link (SBC)	Link (SBC)	Link	Link	Link	
Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Mental/Behavioral health inpatient services	Covered; Supplemented; No Limitations / Exceptions	Covered; Semi-private Room; Hypnotherapy is not covered for any diagnosis or medical condition; Care, services or treatment for non- congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered	Covered; Semi-Private Room	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes Marital, family, educational, or other counseling or training services Testing and treatment for learning disabilities and mental retardation Applied behavior analysis and therapy Services performed by treatment centers, schools, halfway houses Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education Services performed or billed by residential therapeutic camps, light boxes, custodial or long term care	Covered; Excludes Marital, family, educational, or other counseling or training services Testing and treatment for learning disabilities and mental retardation Applied behavior analysis and therapy Services performed by treatment centers, schools, halfway houses Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education Services performed or billed by residential therapeutic camps, light boxes, custodial or long term care	Covered; semiprivate room only Excludes: services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems; Treatment for learning disabilities and mental retardation; telephone therapy, including therapy by remove video connection; travel time to the members home to conduct therapy; services rendered or billed by schools, or halfway houses or members of their staffs, marriage counseling, Applied behavior analysis	Covered; The treating facility must be a Hospital; Coverage is limited to seven (7) inpatient days per year
Substance use disorder outpatient services	Covered; Supplemented; No Limitations / Exceptions	Covered; No Limitations/ Exceptions	Covered; Coverage of office visits and other outpatient treatment sessions, beyond the eighth session in a calendar year, except for medication management treatment sessions, is subject to prior approval from the company	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes Marital, family, educational, or other counseling or training services Testing and treatment for learning disabilities and mental retardation Applied behavior analysis and therapy Services performed by treatment centers, schools, halfway houses Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education Services performed or billed by residential therapeutic camps, light boxes, custodial or long term care	Covered; Excludes Marital, family, educational, or other counseling or training services Testing and treatment for learning disabilities and mental retardation Applied behavior analysis and therapy Services performed by treatment centers, schools, halfway houses Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education Services performed or billed by residential therapeutic camps, light boxes, custodial or long term care	Covered; Same exclusions as Mental/behavioral health services	Covered; Coverage is limited to thirty (30) outpatient visits per year

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	Link				Link (SBC)	Link (SBC)	Link (SBC)	Link	Link	Link	
Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Substance use disorder inpatient services	Covered; Supplemented; No Limitations / Exceptions	Covered; Hypnotherapy is not covered for any diagnosis or medical condition	Covered; Semi-Private Room	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Same exclusions apply as outpatient services	Covered; Same exclusions apply as outpatient services	Covered; Same exclusions as Mental/behavioral health services	Covered; The treating facility must be a Hospital; Coverage is limited to seven (7) inpatient days per year
Prescription Drugs											
Generic drugs	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions
Preferred brand drugs	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions
Non-preferred brand drugs	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions
Rehabilitative / Habilitative Services and Devices											
Rehabilitation services (outpatient)	Covered; Inpatient: 60 days per member per contract year Outpatient: 30 aggregate visits per member per contract year	Covered; Physical, Occupational, and Speech Therapy Limited to 30 aggregate visits per calendar year	Covered; Physical, Occupational, and Speech Therapy Limited to 30 aggregate visits per contract year	Covered; Limited to 20 visits of physical therapy, 20 visits of occupational therapy, 20 manipulative treatments, 20 visits of speech therapy, 36 visits of cardiac rehabilitation therapy, 30 visits of post-cochlear implant aural therapy, 20 visits of cognitive rehabilitation therapy	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes recreational or educational therapy, maintenance or palliative therapy, exercise programs, hippotherapy, massage therapy	Covered; Excludes recreational or educational therapy, maintenance or palliative therapy, exercise programs, hippotherapy, massage therapy	Covered; Up to 60 visits per person per calendar year for the combined services of physical therapists, occupational therapists, speech therapists Must have preauthorization	Covered; Limited to an aggregate maximum of thirty (30) visits per
Habilitation services	Covered; Inpatient: 60 days per member per contract year Outpatient: 30 aggregate visits per member per contract year	Covered; Developmental Services limited to a maximum of 180 units per Covered Person per calendar year; Outpatient Services regarding physical, occupational, and speech therapy limited to 30 aggregate visits per covered person per calendar year; Chiropractic Services Limited to 30 aggregate visits per Covered Person per calendar year	Covered; Developmental Services limited to a maximum of 180 units per Covered Person per contract year; Outpatient Services regarding physical, occupational, and speech therapy limited to 30 aggregate visits per covered person per contract year; Chiropractic Services Limited to 30 aggregate visits per Covered Person per calendar year	Covered; Subject to limits under Rehabilitation Services	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Not Identified	Not Specified	Covered; Up to 60 visits per person per calendar year for the combined services of physical therapists, occupational therapists, speech therapists; Must have preauthorization	Not Specified

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Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Durable medical equipment	Coverage for Medical Supplies used in connection with DME is limited to a 90-day supply per purchase	Covered; Prior Approval for DME for which cost exceeds $5,000	Covered; Prior Approval for DME for which cost exceeds $5,000	Covered; To receive network benefits, you must purchase or rent the Durable Medical Equipment from the vendor the company identifies or purchase it directly from the prescribing Network Physician	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes exercise and bathroom equipment, lifts, Car seats, diabetic supplies, air conditioners, breast pumps, communications equipment	Covered; Excludes exercise and bathroom equipment, lifts, Car seats, diabetic supplies, air conditioners, breast pumps, communications equipment	Covered; Excludes computer devices to assist wit communications, Computer programs of any type, Air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, sun and heat lamps, exercise devices, lifts, wigs, bone stimulators, devices to eliminate bed wetting	Coverage for Medical Supplies used in connection with DME is limited to a 90-day supply per purchase
Laboratory Services											
Diagnostic test (x-ray, blood work)	Covered; No Limitations / Exceptions	Covered; Outpatient services and procedures performed outside PCP Office	Covered; Outpatient services and procedures performed outside PCP Office	Covered; No limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes professional fees for automated lab tests	Covered; No Limitations / Exceptions
Imaging (CT/PET scans, MRIs)	Covered; No Limitations / Exceptions	Covered; Outpatient services prior approval required	Covered; Outpatient services prior approval required	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Maximum of one (1) copayment per member per year	Covered; Maximum of one (1) copayment per member per year	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Excludes professional fees for automated lab tests	Covered; Prior Approval Required
Preventive and Wellness Services and Chronic Disease Management											
Preventive care/screening/immunization	Covered; No Limitations / Exceptions	Covered; No Limitation / Exceptions	Covered; No Limitation / Exceptions	Covered; Well baby and well child care includes, but is limited to, 20 visits	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; No Limitations / Exceptions	Covered; Preventive care benefits are limited to one per year BRAC testing is limited to one test per lifetime	Covered; Preventive care benefits are limited to one per year BRAC testing is limited to one test per lifetime	Covered; Excludes professional fees for automated lab tests	Covered; Limitations based on procedure
Pediatric Services, Including Oral and Vision Care											
Children's Eye exam	Covered; Supplemented; Limit 1 per year	Covered; Annual routine eye examinations with refraction are covered beginning at age six, or earlier if medically indicated, through age 18	Covered; Annual routine eye examinations with refraction are covered beginning at age six, or earlier if medically indicated, through age 18	Covered; Via Rider	Limited benefit of one exam every twenty-four (24) months	Limited benefit of one exam every twenty-four (24) months	Limited benefit of one exam every twenty-four (24) months	Not Covered	Not Covered	Not Covered	Not Covered

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	Link				Link (SBC)	Link (SBC)	Link (SBC)	Link	Link	Link	
Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Children's Glasses	Covered; Supplemented; Limit 1 per year	Covered; One pair of lenses in a calendar year, if prescribed by a physician; One frame in a calendar year if lenses are prescribed and prescription glasses selected	Covered; One pair of lenses in a contract year, if prescribed by a physician; One frame in a contract year if lenses are prescribed and prescription glasses selected	Covered; Via Rider	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Children's Dental check-up	Covered; Supplemented; Limited 2 per year, extensions available when consultation is medically necessary	Not Covered	Not Covered	Covered; Via Rider	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
State-Mandated Benefits											
In-vitro Fertilization	Not Covered	Covered; subject to prior approval, Limited to four completed oocyte retrievals per lifetime or two live births from separate pregnancies, except that two completed oocyte retrievals are covered after a first live birth is achieved as a result of a successful in vitro fertilization cycle	Not Covered	Covered; Limited to a lifetime maximum of $15,000	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
TMJ	Not Identified	Covered; No Limitation / Exceptions	Covered; No Limitation / Exceptions	Covered; Limited to $3,000 per year	Not Identified	Not Identified	Not Identified	Covered; No Limitations / Exclusions	Covered; No Limitations / Exclusions	Covered; No Limitations / Exclusions	Not Covered
Hearing Aids	Not Covered	Covered; Limited to $1,400 per ear, for each three-year period	Covered; Limited to $1,400 per ear, for each three-year period	Covered; Limited to $2,800 per calendar year, but shall at least be $1,400 per ear Benefits are limited to a single purchase every three years	Covered; No Limitations / Exclusions	Covered No Limitations / Exclusions	Covered, No Limitations / Exclusions	Covered; For children up to age 22, limited to $2,500 per calendar year For adults age 22 and over, limited to $2,500 every 3 calendar years	Covered; For children up to age 22, limited to $2,500 per calendar year For adults age 22 and over, limited to $2,500 every 3 calendar years	Covered; Benefit is payable per person every five years	Not Covered

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	Link				Link (SBC)	Link (SBC)	Link (SBC)	Link	Link	Link	
Benefit	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage**
Craniofacial Anomaly Corrective surgery	Not Identified	Covered; Reconstructive surgery covered on a child for the correction of a congenital abnormality Must be performed when the child is 12 years of age or younger, unless, in its sole discretion the Company determines that due to the complexity of the procedure , such surgery could not be performed prior to the child's 12th birthday	Covered; Reconstructive surgery covered on a child for the correction of a congenital abnormality Must be performed when the child is 12 years of age or younger, unless, in its sole discretion the Company determines that due to the complexity of the procedure , such surgery could not be performed prior to the child's 12th birthday	Covered; No Limitations / Exceptions	Not Identified	Not Identified	Not Identified	Covered; Must get prior approval for outpatient surgical correction of congenital anomalies	Covered; Must get prior approval for outpatient surgical correction of congenital anomalies	Covered; Must be under the age of 18 unless there is a functional deficit	Covered; Must be performed when the child is 12 years of age or younger, unless, in its sole discretion Health Advantage determines that do to the complexity of the procedure, such surgery could not be performed prior