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

	BCBS Comp Major Medical PPO	Health Advantage Open Access POS	Qual Choice	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	Qual Choice Federal Plan	State and Public School Employee Plan
	Coverage	Coverage	Coverage	Coverage	Coverage		Coverage
Ambulatory Patient Services							
General ambulatory	Covered	Covered	Covered	Covered	Covered	Covered	Covered, office visits for physican and specialist, OP or IP
Home health services	Covered	Covered	Covered	Covered, limited to 2 hours per day, 25 visits/year	Covered, limited to 2 hours per day, 25 visits/year	Covered, limit 40 visits per year	Covered, subject to coinsurance
Physical/Occupational Therapy	Covered	Covered	Covered, with limits on visits not specified	75 visits/year aggregate (OT, PT, Speech combined)	50 visits/year aggregate (OT, PT, Speech combined)	Covered, limited to 60 visits or 2 consecutive months per condition	Covered subject to coinsurance
Speech Therapy	Covered	Covered	Covered, with limits on visits not specified	75 visits/year aggregate (OT, PT, Speech combined)	50 visits/year aggregate (OT, PT, Speech combined)	Covered, limited to 60 visits or 2 consecutive months per calendar year	Covered subject to coinsurance
Chiropractic Care	Not covered	Covered	Covered, with limits on visits not specified	Covered, 12 visits per year	Covered, 20 visits per year	Covered, lifetime limit of 20 visits	Covered, limit 15 visits per plan year
Acupuncture as Anesthesia	Not covered	Not covered	Not covered	Covered, 24 visits/year	Covered	Not covered, unless used as anesthesia	Not covered
Weight loss programs	Not covered	Not covered	Not covered	Not covered	Not covered	Not specified	Obesity services provided through physician office visits
Infertility treatment	Covered	Covered	Covered	Limited Coverage	Limited Coverage	Covered, with exclusions	Only testing/diagnostics, no treatment
Emergency Services							
General services	Covered	Covered, subject to in-network deductible and coinsurance when care is received w/in 48 hrs of emergency	Covered	Covered	Covered	Covered	Covered
Emergent Transportation	Covered	Ground, water, air are covered, limited to $1000/trip for ground/water and $5000 for air		Ground, water, air are covered, limited to $1000/trip for ground/water and $5000 for air	Ground, water, air are covered, limited to $1000/trip for ground/water and $5000 for air		Covered, limited to $2000 per trip for ground transportation
Hospitalization							
General hospital services	Covered	Covered	Covered	Covered	Covered	Covered	IP, OP, and diagnostic covered, subject to coinsurance and copayment
Hospice	Covered	Covered	Covered, with limits not specified	Covered	Covered	Covered	Covered, subject to coinsurance
Skilled nursing facility	Covered	Covered, 30 days per calendar year, admitted within 7 days of release from hospital	Covered, with limits not specified	Covered (limited to members with Medicare Part A)	Not covered	Covered, limited to 60 days per calendar year	Covered, subject to coinsurance and copayment
Bariatric Surgery	Covered	Not covered	Not covered	Covered	Covered	Covered	Covered through pilot program
Maternity and Newborn Care							
Maternity services	Covered	OB and newborn care covered; midwives not covered	Covered	Covered	Covered	Covered	Covered, including pre- and post-natal OP care
Mental Health and Substance Use Disorder							
Inpatient treatment - psychiatric / SA	Covered	7 days per year	Covered under MH Parity rider	Covered	Covered	Covered for approved treatment programs only	covered, including residential and IP
Outpatient treatment - psychiatric / SA	Covered	Covered	Covered under MH Parity rider	Covered	Covered	Covered for approved treatment programs only	covered, including day treatment
Substance Abuse - addiction / alcoholism	Covered	Covered	Covered under MH Parity rider			Covered for approved treatment programs only	covered
Prescription Drugs							
	Covered	Not Covered (Offered)	Covered	Covered	Covered	Covered	Covered, three tiers plus OTC program with copays
Rehabilitative / habilitative services and devices							
Durable Medical Equipment	Covered	Covered	Covered, with annual dollar limits	Covered	Covered	Covered	Covered, subject to coinsurance
Hearing Aids	Not Covered (Offered)	Not Covered (Offered)	Not covered, only cochlear implants	Optional coverage	Covered	Covered	Covered, limit 1400 per ear every three years
Habilitative Services and Devices	Federal requirements unclear	Federal requirements unclear	Prosthetics and Orthotics covered	Not specified	Not specified	Prosthetics and orthotic devices covered	Prosthetic and orthotic devices, covered subject to coinsurance
TBI	Covered	Rehab facility covered if admitted w/in 7 days of release	Not specified	Not specified	Not specified	Not specified	Not specified
Laboratory Services							
	Coverd	Covered	Covered	Covered	Covered	Covered	Radiology, additional charges apply for MRI, MRA, CTA, and PET Scans
CD Management							
Chronic Management	Diabetes management is covered, limited to one management training program per lifetime, one eye exam per calendar year, and associated DME	One Diabetes Management Training Program/lifetime		Covered	Covered	Covered	Diabetes management
	Routine immunizations	Preventative Health Services Covered	routine vision exams covered	Preventative Health Services Covered	Preventative Health Services Covered	Preventive Health Services covered	Preventive Health Services covered
	Services receiving A or B rating from US Preventive Services Task Force					Routine vision exam is covered	Allergy testing, immunizations covered
Pediatric Services, including oral and vision care							
	Children's preventive services are covered, oral and vision assessments covered	Preventative Health Services Covered	Not specified	Covered, including routine oral and vision assessments	Covered, including routine oral and vision assessments	Covered for prevention and diagnostics	Children's preventive care
							*transplant services also covered