EHB Benchmark and State Mandated Benefits Comparison

Plan Type	Largest small group product, PPO						
Product Name	BlueOptions PPO						
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)						
Benefit	**EHB?**	**State Mandated Benefit?**	**Benefit Description (All benefit data corresponds to the EHB unless otherwise noted)**	**Quantitative Limit on Service?**	**Limit Quantity**	**Limit Unit and/or Description**	**Explanations**
Bariatric Surgery	Yes		Bariatric Surgical Procedures	No			Only as medical necessity. Not covered when related to weight reduction.
Basic Dental Care - Child	Yes		Basic Dental Care - Child	No			Limitations, including dollar limits, may apply.
Bone Density Tests	Yes	Yes					
Breast Cancer Treatment	Yes	Yes					
Chiropractic Care	Yes	Yes	Chiropractic Manipulation	Yes	25	Visits per year	Chiropractic office Visits are not limited to 25, only PT is limited. Same benefit as combination of Physical Therapy, Occupational Therapy and Manipulative Therapy and habilitation.
Congenital Anomaly, including Cleft Lip/Palate	Yes		Congenital Anomaly, including Cleft Lip/Palate	No			
Cosmetic Surgery	Yes		Cosmetic Surgery (Medically Necessary)	No			For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless: needed to repair conditions resulting from an accidental injury; or for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.
Delivery and All Inpatient Services for Maternity Care	Yes		Maternity Service	No			
Dental Check-Up for Children	Yes		Dental Exams	Yes	2	Visits per year	Limitations, including dollar limits, may apply. Supplemented using Oklahoma CHIP.
Dental Anesthesia	Yes	Yes	Dental Anesthesia	No			
Diabetes Care Management	Yes	Yes	Diabetes Care Management	No			

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Diagnostic Test (X-Ray and Lab Work)	Yes	Yes	Diagnostic Test	No			
Durable Medical Equipment	Yes		Durable Medical Equipment	No			
Emergency Room Services	Yes	Yes	Emergency Room Visit	No			
Emergency Transportation/ Ambulance	Yes		Ambulance Transportation	No			
Eye Care (Medically Necessary)	Yes	Yes					
Eye Exam for Children	Yes		Routine eye exam	Yes	1	Visit per year	
Eye Glasses for Children	Yes		Eye Glasses for Children	Yes	1	1 pair of glasses (lenses and frames) per year	
Generic Drugs	Yes		Generic Drugs	No			
Habilitation Services	Yes		Rehabilitation Services	Yes	25	Visits per year	Same benefit as combination of Physical Therapy, Occupational Therapy and Manipulative Therapy.
Hearing Aids	Yes		Hearing Aid	Yes	1	Hearing aid per ear every 48 months for Subscribers up to age 18.	
Hearing Exams and Aids for Children	Yes	Yes					
Home Health Care Services	Yes	Yes	Coordinated Home Care Program	Yes	30	Visits per year Per benefit	
Hospice Services	Yes		Hospice Care	No			
Imaging (CT/PET Scans, MRIs)	Yes		Diagnostic Test	No			
Infertility Treatment							Diagnosis is covered, treatment is not covered.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Inpatient Hospital Services	No			
Inpatient Physician and Surgical Services	Yes		Inpatient Hospital Services	No			
Laboratory Outpatient and Professional Services	Yes	Yes	Laboratory Outpatient and Professional Services	No			
Major Dental Care - Child	Yes		Major Dental Care - Child	No			Limitations, including dollar limits, may apply.
Mental Health Other	Yes		Mental Health Other	No			

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Mental/Behavior al Health Inpatient Services	Yes	Yes	"Severe Mental Illness Treatments" mandated coverage by the state	Yes	30	Days per year	
Mental/Behavior al Health Outpatient Services	Yes	Yes	20 visits mandated by the state	Yes	20	Visits per year	
Non-Preferred Brand Drugs	Yes		Non-Preferred Brand Drugs	No			
Orthodontia - Child	Yes		Orthodontia - Child	No			Limitations, including dollar limits, may apply. Medically necessary orthodontia only.
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Provider office Visit	No			
Outpatient Rehabilitation Services	Yes	Yes	Rehab. Phys Therapy a state mandated benefit	Yes	25	Visits per year	Combination of Physical Therapy, Occupational Therapy and Manipulative Therapy. Same Benefit as habilitation Chiropractic Benefit Below.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes	Outpatient Hospital Services	No			
Outpatient Surgery Physician/Surgica l Services	Yes		Outpatient or ambulatory surgical procedures	No			
Postnatal Newborn Injury or Sickness	Yes	Yes	Maternity Service				
Preferred Brand Drugs	Yes		Preferred Brand Drugs	No			
Prenatal and Postnatal Care	Yes		Maternity Service	No			
Prescription Drugs Other	Yes		Prescription Drugs Other	No			
Preventive Care/ Screening/ Immunization	Yes	Yes	Colorectal Cancer Screenings, Mammography Screening, "preventative services", and Immunizations coverage mandated by state	No			
Primary Care Visit to Treat an Injury or Illness	Yes		Physician Office Visits	No			
Private-Duty Nursing	Yes		Private Duty Nursing Service	Yes	85	Visits per year	
Reconstructive Surgery	Yes		Reconstructive Surgery	No			
Routine Foot Care	Yes		Routine Foot Care	No			Covered only for diabetic members.
Scalp Prosthesis	Yes	Yes					
Skilled Nursing Facility	Yes		Skilled Nursing Facility Services	Yes	30	Days per year	
Specialist Visit	Yes		Specialty Provider Visit	No			
Specialty Drugs	Yes		Specialty Drugs	No			
Substance Abuse Disorder Inpatient Services	Yes		Mental health and substance abuse services	Yes	30	Days per year	Visit Limits combined with mental health visit limits.
Substance Abuse Disorder Outpatient Services	Yes		Mental health and substance abuse services	Yes	20	Visits per year	Visit Limits combined with mental health visit limits.
Substance Abust - Chemical Dependency-Detoxification	Yes	Yes					

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Urgent Care Centers or Facilities	Yes		Urgent Care Services	No			
Weight Loss Programs							Covered under diabetes self-management.
X-rays and Diagnostic Imaging	Yes	Yes	X-rays and Diagnostic Imaging	No			