

### Rhode Island EHB Benchmark Plan Options: 2017

**\*\*Benefits provided by potential EHB as of 3/31/2014**

**\*\*Not all cost-sharing and prior authorization requirements are in this document**

**\*\*Blank cells indicate that there was not enough information to make a determination**

Benefit	Three Largest RI Small Group Plans		
	UnitedHealthcare Choice Plus	VantageBlue w/ Rx	BlueSolutions for HSA w/ RX
<b><u>Essential Health Benefits</u></b>			
<b>Ambulatory Patient Services</b>			
A. Home Health Care	Y	Y	Y
B. Hospital based clinic visits	Y	Y	Y
C. Specialist house calls	Y	Y	Y
D. Personal Care Physician (sick visit)	Y	Y	Y
E. Specialist Visits	Y	Y	Y
F. Allergist and Dermatologist	Y	Y	Y
G. Chemotherapy/Radiation Therapy	Y	Y	Y
H. Surgery (Outpatient/ Doctor's Office)	Y	Y	Y
I. Personal Care Physician House Calls	Y	Y	Y
J. Therapeutic Treatments - Outpatient	Y	Y	Y
K. Special Medical Formulas	See other state mandate B below	See other state mandate B below	See other state mandate B below
<b>Emergency Services</b>			
A. Emergency Room - Facility	Y	Y	Y
B. Ambulance	Y	Ground: Y; Air/Water: limited - maximum benefit \$3,000 per occurrence.	Ground: Y; Air/Water: limited - maximum benefit \$3,000 per occurrence.
C. Urgent Care Services and Facilities	Y	Y	Y
<b>Hospitalizations</b>			

	Y	Y	Y
A. Hospice			
B. Inpatient Hospital Services	Y	Y	Y
C. Inpatient Physician Hospital Visits	Y	Y	Y
	Y	Y	Y
D. Organ Transplants			
E. Respiratory Therapy	Y	Y	Y
	Y	Y	Y
F. Inpatient Surgery	Specifically includes congenital heart disease surgeries, obesity surgery, and reconstructive procedures.	Y	Y
<b>Maternity and Newborn Care</b>			
A. Pregnancy Services and Nursery Care - Pre-natal, delivery, and post-partum services	Y	Y	Y
B. Abortion	Y	Y	Y
C. Nurse Midwife	See other state mandate B below	Y	Y
D. Hearing Screening for Newborn	Preventive service covered under ACA	Preventive service covered under ACA	Preventive service covered under ACA
<b>Mental Health and Substance Abuse Disorder Services, Including Behavioral Health Treatment</b>			
A. Inpatient	Y	Y	Y
B. Intermediate	Y	Y	Y
C. Outpatient - PCP or Specialist	Y	Y	Y
D. Substance Abuse Treatment Facility - Inpatient	Y	Y	Y
E. Substance Abuse Treatment Facility - Outpatient	Y	Y	Y
F. Substance Abuse Outpatient - PCP or Specialist	Y	Y	Y
<b>Prescription Drugs</b>			
A. Infusion Therapy	Y	Y	Y

B. Injectable Drugs	Limited Does not cover self-injectable medications (insulin and diabetic supplies are covered).	Y	Y
C. Retail Pharmacy	Y	Y	Y
D. Mail Order Pharmacy	Y	Limited Nicotine replacement therapy (NRT) and smoking cessation prescription drugs are not covered when purchased at a mail order pharmacy	Limited Nicotine replacement therapy (NRT) and smoking cessation prescription drugs are not covered when purchased at a mail order pharmacy
E. Infertility Prescription drugs	Y	Limited Married female members 25 to 42; 3 infertility treatment cycles covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime	Limited Married female members 25 to 42; 3 infertility treatment cycles covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime
F. Contraceptive Methods	Y	Y	Y
G. OTC Preventive Drugs Purchased at a Pharmacy	Not Covered Over-the-counter nicotine replacement drugs may be covered.	Y	Y
H. Diabetes, Asthma, and COPD Prescription Drugs	Y	Y	Y
I. NRT and Smoking Cessation Prescription Drugs	Y	Limited Not covered when purchased at a mail order pharmacy.	Limited Not covered when purchased at a mail order pharmacy.
J. Specialty Prescription Drugs when purchased at a Specialty Pharmacy	Y	Y	Y
K. Specialty Prescription Drugs when purchased at a Retail Pharmacy	Y	Y Reimbursed at the non-network level of coverage.	Y Reimbursed at the non-network level of coverage.
L. Specialty Prescription Drugs when purchased at a Mail Order Pharmacy	Y	Not Covered	Not Covered

M. Infertility Specialty Drugs purchased at Specialty Pharmacy	May Be Limited "Coverage is determined by the consumer's prescription drug benefit plan."	Limited 3 infertility treatment cycles will be covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime.	Limited 3 infertility treatment cycles will be covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime.
N. Infertility Specialty Drugs purchased at Retail Pharmacy	May Be Limited "Coverage is determined by the consumer's prescription drug benefit plan."	Limited 3 infertility treatment cycles will be covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime. Specialty Prescription Drugs purchased at a Retail Pharmacy are reimbursed at the non-network level of coverage.	Limited 3 infertility treatment cycles will be covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime. Specialty Prescription Drugs purchased at a Retail Pharmacy are reimbursed at the non-network level of coverage.
O. Diabetic Equipment and Supplies (purchased at Retail/Specialty/ or Mail Order Pharmacy)	Y	Y	Y
P. Hypodermic Needles	See other state mandate I below	See other state mandate I below	See other state mandate I below
Q. Prescription Drugs (Generic, Preferred, Non-Preferred, Specialty)	Y	Y	Y
<b>Rehabilitative and Habilitative Services and Devices</b>			
A. Cardiac Rehabilitation	Limited 36 visits.	Limited 18 weeks or 36 visits (whichever occurs first) per covered episode.	Limited 18 weeks or 36 visits (whichever occurs first) per covered episode.
B. Outpatient Durable Medical Equipment	Y	Y	Y
C. Outpatient Medical Supplies	Y Specifically covers ostomy supplies.	Y	Y
D. Outpatient Prosthesis	Y	Y	Y
E. Inpatient Rehabilitation Facility	Y	Limited Maximum of 45 plan days per year.	Limited Maximum of 45 plan days per year.
F. Physical and Occupational Therapy - Outpatient/Doctor's/Therapist's Office	Y	Y	Y
G. Speech Therapy	Y	Y	Y

H. Post-cochlear Implant Aural Therapy	Limited 30 visits.		
I. Pulmonary Rehabilitation	Limited 20 visits.	Y Covered as Respiratory Therapy	Y Covered as Respiratory Therapy
J. Cognitive Therapy	Limited 20 visits.	Y Covered as behavioral health benefit	Y Covered as behavioral health benefit
K. Vision Therapy	Y		
L. TMJ Services	Y	Not Covered	Not Covered
M. Speech Generating or Communication Device	Not Covered		
<b>Laboratory Services</b>			
A. Tests, Imaging, and Labs	Y	Y	Y
<b>Preventive and Wellness Services and Chronic Disease Management</b>			
A. Diabetic Services	Y	Limited Podiatrist and vision are office visit limited to first routine visit of the plan year.	Y
B. Dialysis	Y	Y	Y
C. Asthma Management		Y	Y
D. Hearing Exam/Diagnostic Testing	Y	Y	Y
E. Podiatrist Services	Limited Routine foot care is not covered except as a preventive service for persons with diabetes.	Limited Routine foot care is not covered except when performed to treat diabetic related nerve and circulation disorders of the feet.	Limited Routine foot care is not covered except when performed to treat diabetic related nerve and circulation disorders of the feet.

F. Adult Annual Preventive Visit	Y	Limited 1 routine adult physical examination per plan year per member.	Limited 1 routine adult physical examination per plan year per member.
G. Well Woman Annual Preventive Visit	Limited Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).	Limited 1 routine gynecological examination per plan year per female member	Limited 1 routine gynecological examination per plan year per female member
H. Diabetes Education	Y	Y	Y
I. Nutritional Counseling	Y	Y	Y
J. Smoking Cessation Counseling	Y	Y	Y
K. Adult Immunization	Y	Y	Y
L. Travel Immunization	Not Covered	Y	Y
M. Allergy Injections	Y	Y	Y
N. Preventive Screenings	Y	Y	Y
O. Genetic Counseling for BRCA	Y	Y	Y
P. Contraceptive and Sterilization Services for Women	Limited Does not cover voluntary sterilization.	Y	Y
Q. Manual Breast Pump (in conjunction with birth)	Y	Y	Y
R. Hemophilia Services		Y	Y

S. Diagnostic Colorectal Services	Y	Y	Y
T. Lyme Disease Diagnosis and Treatment	Y	Y	Y
<b>Pediatric Services (Including Oral and Vision)</b>			
A. Pediatric Clinic Visit	Y	Y	Y
B. Pediatric Preventive Office Visit	Y	Limited Birth to 15 months: limited to 8 visits; 16- 35 months: limited to 3 visits; 36 months to 19 years: limited to 1 visit per plan year	Limited Birth to 15 months: limited to 8 visits; 16- 35 months: limited to 3 visits; 36 months to 19 years: limited to 1 visit per plan year
C. Pediatric Preventive Clinic		Y	Y
D. Pediatric Immunization	Y	Y	Y
E. Vision Care Services	Y Covers 1 pair of glasses or contacts.	Limited 1 pediatric vision exam for a member up to age 19; 1 pair of collection prescription frames per plan year, non-collection frames are not covered; 1 pair of glass or plastic lenses per plan year; 1 pair of collection contact lenses in lieu of prescription glasses	Limited 1 pediatric vision exam for a member up to age 19; 1 pair of collection prescription frames per plan year, non-collection frames are not covered; 1 pair of glass or plastic lenses per plan year; 1 pair of collection contact lenses in lieu of prescription glasses
F. Autism Spectrum Disorder (ASD) services	Y	Related services covered (e.g. early intervention, PT/OT, Speech Therapy)	Related services covered (e.g. early intervention, PT/OT, Speech Therapy)
G. Pediatric Dental	Y	Not covered unless embedded	Not covered unless embedded
<b><u>Other State Mandates</u></b>			
A. Human Leukocyte Antigen Testing, RIGL 27-20-36	Y	Y	Y
B. Non-prescription enteral formula for certain conditions when medically necessary, RIGL 27-20-56, 27-18-70	Y	Y Feeding tube (must be sole source of nutrition) and oral	Y Feeding tube (must be sole source of nutrition) and oral
C. Early Intervention Services for children up to age 3, \$5,000 annual limit, RIGL 27-20-50	Y	Limited For children from birth to 36 months	Limited For children from birth to 36 months.

D. Hair Protheses for cancer patients, up to \$350 per year, RIGL 27-20-54	Y	Limited \$350 per wig when worn for hair loss suffered as a result of cancer treatment.	Limited \$350 per wig when worn for hair loss suffered as a result of cancer treatment.
E. Hearing aids limited to \$1,500 every 3 years for members under age 19 and \$700 every 3 years for members age 19 and up, RIGL 27-20-46	Limited To a single purchase per ear (including repair/replacement) of a hearing aid every 3 years for Covered Persons.	Limited \$1500 per ear per hearing aid for a member under 19; \$700 per ear per hearing aid for a member 19 and older.	Limited \$1500 per ear per hearing aid for a member under 19; \$700 per ear per hearing aid for a member 19 and older.
F. Infertility Services, with a lifetime limit of \$100,000, RIGL 27-20-20	Limited Married female members 25 to 42.	Limited Married, unable to conceive or sustain a pregnancy for 1 year, presumably healthy individual 3 infertility treatment cycles will be covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime.	Limited Married, unable to conceive or sustain a pregnancy for 1 year, presumably healthy individual 3 infertility treatment cycles will be covered per plan year with a total of 8 infertility treatment cycles covered in a member's lifetime.
G. Coverage for individuals participating in approved clinical trials; RIGL 27-20-60	Y	Y Specifically covered to the extent required by state law.	Y Specifically covered to the extent required by state law.
H. Coverage for the services of licensed midwives, RIGL 27-18-31	Y	Y	Y
I. Equipment & supplies for treatment of diabetes including glucose monitore, test strips, syringes, insulin pumps, molded shoes RIGL, 27-20-30	Y	Y	Y
<b><u>Other Services</u></b>			
A. Chiropractic Services	Limited 20 visits.	Limited 12 visits.	Limited 12 visits.
B. Dental Care	Limited Accident only.	Limited Accidental injury to sound natural teeth.	Limited Accidental injury to sound natural teeth.
C. Private Duty Nursing	Y	Y	Y
D. Skilled Nursing Facility Care	Y	Y	Y

E. Vision Care Services	<p>Limited 1 routine eye exam per year for Covered Persons 19 years of age and older</p>	<p>Limited 1 routine eye exam per plan year, medically necessary eye exams are covered. Vision hardware for members 19 and older is not covered.</p>	<p>Limited 1 routine eye exam per plan year, medically necessary eye exams are covered. Vision hardware for members 19 and older is not covered.</p>
G. Acupuncture	<p>Limited 10 treatments per year for pain therapy or nausea related to surgery, pregnancy, or chemotherapy.</p>	<p>Not Covered</p>	<p>Not Covered</p>