

EHB Benchmark Template v2.81

Instructions: All fields with an asterisk (*) are required. Please press the Validate button once finished to validate that all data in the workbook is correct.
 For each benefit listed, select if it is Covered or Not Covered. If a benefit is covered, fill out the additional information.
 For any benefit that has different limitations or restrictions, answer "Yes" on the limitations and restrictions column, do not add rows.
 To add benefits not listed, please use the "Other Benefits" button at the bottom of the sheet, you will not be able to add rows to the first sheet.

Benefit	Covered*	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units	Other Limit Units Description	Minimum Stay	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?
	Required: Is benefit Covered or Not Covered	Required if benefit is Covered: Enter a Description, it may be the same as the Benefit name	Required if benefit is Covered: Select "Yes" if Quantitative Limit applies	Required if Quantitative Limit is "Yes": Enter Limit Quantity	Required if Quantitative Limit is "Yes": Select the correct limit units	Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description	Optional: Enter the Minimum Stay (in hours) as a whole number	Optional: Enter any Exclusions for this benefit	Optional: Enter an Explanation for anything not listed	Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described
Primary Care Visit to Treat an Injury or Illness	Covered	Primary Care Office Visit	No							No
Specialist Visit	Covered	Specialist Visit	No							No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visits	No							Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Surgery Facility Fee (e.g. Ambulatory Surgery Center)	No							Yes
Outpatient Surgery Physician/Surgical Services	Covered	Outpatient Surgery Physician Services	No							Yes
Hospice Services	Covered	Hospice Services	No						Covered when provided by an approved hospice care program	No
Non-Emergency Care When Traveling Outside the U.S.	Covered	Care when Traveling Outside the U.S.	No							No
Routine Dental Services (Adult)	Not Covered	Dental Services								
Infertility Treatment	Covered	Infertility Treatment	No					Infertility treatment for a person that previously had a voluntary sterilization procedure is not	Coverage is provided when the member is married, unable to conceive or sustain a	Yes
Long-Term/Custodial Nursing Home Care	Not Covered	Long-Term Care							Covered when received in your home when medically necessary, ordered by a	No
Private-Duty Nursing	Covered	Private-Duty Nursing	No							No
Routine Eye Exam (Adult)	Covered	Routine Eye Exam	Yes		1 Visits per year					No
Urgent Care Centers or Facilities	Covered	Urgent Care Center Visits	No							No
Home Health Care Services	Covered	Home Health Care Services	No							No
Emergency Room Services	Covered	Emergency Room Services	No							No
Emergency Transportation/Ambulance	Covered	Ambulance (ground transportation)	No					This plan does not provide coverage for transportation to a physician's office.		Yes
Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services	No							Yes
Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No							Yes
Bariatric Surgery	Covered	Bariatric Surgery	No							No
Cosmetic Surgery	Not Covered	Cosmetic Surgery							This plan does not cover cosmetic procedures when performed primarily to refine or	
Skilled Nursing Facility	Covered	Skilled Nursing Facility	No					Custodial Care is not covered.		No
Prenatal and Postnatal Care	Covered	Pregnancy Services and Nursery Care	No							No
Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and Inpatient Maternity Care	No							No
Mental/Behavioral Health Outpatient Services	Covered	Mental/Behavioral Health Outpatient Services	No					This plan does not cover recreation therapy, non-medical self-care, or self-help training.		Yes
Mental/Behavioral Health Inpatient Services	Covered	Mental/Behavioral Health Inpatient Services	No					This plan does not cover recreation therapy, non-medical self-care, or self-help training.		No
Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Disorder Outpatient Services	No					This plan does not cover methadone clinics and treatments.		No
Substance Abuse Disorder Inpatient Services	Covered	Substance Abuse Disorder Inpatient Services	No					This plan does not cover methadone clinics and treatments.		No

