DRAFT FOR DISCUSSION ONLY

Exhibit 1
New York State
Essential Health Benefits Study
Review of State Mandates and Potential Benchmark Plans

	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
							Largest non-Medicaid HMO	3 Largest Small Group Products		
REQUIRED BENEFITS	BCBS Basic	BCBS Standard	GEHA	Empire Plan	CDPHP HMO	IHA HMO	HIP PRIME	Oxford EPO	Oxford HMO	Oxford Direct
Autism Related Services	Does not cover ABA	Does not cover ABA	Does not cover ABA	Yes, when new statute implemented	Yes, when new statute implemented	Yes, when new statute implemented	Yes, when new statute implemented	Yes, when new statute implemented	Yes, when new statute implemented	Yes, when new statute implemented
Bone Density Measurement	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Probably Yes	Probably Yes	Probably Yes
Cancer Drugs (Off-Label Drug Use)	Unknown	Unknown	Unknown	Yes	Yes, in Rx Rider	Yes, in Rx Rider	No (Non-Rx Plan)	Yes, in Rx Rider	Yes, in Rx Rider	Yes, in Rx Rider
Cancer Drugs (Oral Cancer Medications)	Yes	Yes	Yes	Yes	Yes, in Rx Rider	Yes, in Rx Rider	No (Non-Rx Plan)	Yes, in Rx Rider	Yes, in Rx Rider	Yes, in Rx Rider
Cervical Cancer/HPV Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chemical Abuse and Dependency - Outpatient	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chiropractic Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Contraceptives	Yes	Yes	Yes	Yes	Yes, in Rx Rider	Yes, in Rx Rider	No (Non-Rx Plan)	Yes, Supplemental with Rx Rider	Yes, Supplemental with Rx Rider	Yes, Supplemental with Rx Rider
Diabetes Self-Management Education	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Diabetic Supplies and Equipment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Eating Disorder Care Center	Unknown	Unknown	Unknown	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements
Enteral Formula for Home Use	Yes, with a prescription	Yes, with a prescription	Yes, with a prescription	No	Yes, in Rx Rider	Yes, in Rx Rider	No (Non-Rx Plan)	Yes, in Rx Rider	Yes, in Rx Rider	Yes, in Rx Rider
Emergency Medical Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Experimental or Investigational Services recommended by external appeal agent (Cancer)	No	No	No	Yes	When an exception is made	When an exception is made	When an exception is made	When an exception is made	When an exception is made	When an exception is made
Home Health Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Infertility Coverage (Drugs covered)	No	No	No	Yes	Yes, in Rx Rider	Yes, in Rx Rider	No (Non-Rx Plan)	Yes, in Rx Rider	Yes, in Rx Rider	Yes, in Rx Rider
Mammography Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mastectomy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mastectomy Minimum Stay	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maternity	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maternity Minimum Stay	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medical Conditions Leading to Infertility (Diagnostic and Treatment)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mental Health General	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes, Supplemental	Yes, Optional Rider	Yes, Supplemental
Mental Health Parity	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes, Supplemental	Yes, Optional Rider	Yes, Supplemental
Post-Mastectomy Reconstruction	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pre-admission Testing	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pre-hospital Emergency Medical Services (Ambulance Transportation and Services)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prostate Cancer Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes Amended	Yes	Yes	Yes
Second Medical Opinion (Cancer Diagnosis)	Unknown	Unknown	Unknown	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Second Surgical Opinion	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Covered under PPACA as preventive services
Likely considered one of 10 Essential Health Benefit categories

DRAFT FOR DISCUSSION ONLY

Appendix A
New York State
Essential Health Benefits Study
Summary of Covered Services for Potential Benchmark Plans

	Affordable Care Act	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
									3 Largest Small Group Products		
TYPE OF SERVICE	**Identified as Essential Health Benefits**	**Basic Option**	**Standard Option**	**GEHA**	**Empire Plan**	**CDPHP**	**Independent Health**	**Largest non-Medicaid HMO (HIP Prime)**	**Oxford HMO**	**Oxford EPO**	**Oxford Direct**
Inpatient Hospital Services	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Outpatient Hospital Services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Preadmission Testing		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Emergency Medical Services	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Maternity Care	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Including newborn care	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Midwifery Services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Skilled Nursing Care Facility		Not Covered	Covers all charges for 30 days.	Covered, 14 Day Max	Covered	Covered, 45 Day Limit	Covered, 45 Day Limit	Covered, unlimited days	Covered, 200 days per calendar year. Riders are available for unlimited coverage.	Covered, 200 days per calendar year. Riders are available for unlimited coverage.	Covered, 200 days per calendar year. Riders are available for unlimited coverage.
Hospice		Covered, primarily through home care	Covered, primarily through home care	Covered, $15,000 per year max	Covered	Covered, 210 day limit	Covered	Covered, 210 day limit	Covered, 210 days per calendar year combined inpatient/outpatient days. (One outpatient visit, either facility based or at home, equals 1 day.)	Covered, 210 days per calendar year combined inpatient/outpatient days. (One outpatient visit, either facility based or at home, equals 1 day.)	Covered, 210 days per calendar year combined inpatient/outpatient days. (One outpatient visit, either facility based or at home, equals 1 day.)
Home Health Care Services		Covered, 25 visits per calendar year	Covered, 25 visits per calendar year	Covered, 50 visits per calendar year	Covered	Covered	Covered, 40 visits per calendar year	200 visits per calendar year	Covered, 40 visits per calendar year.	Covered, 40 visits per calendar year.	Covered, 40 visits per calendar year.
Therapy Treatments											
- Chemotherapy		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Radiation		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Renal Dialysis		Covered	Covered	Covered	Covered	Covered	Covered	Covered. **R** for out of network coverage.	Covered. **R** for out of network coverage at in network rates when traveling	Covered. **R** for out of network coverage at in network rates when traveling	Covered. **R** for out of network coverage at in network rates when traveling
Second Surgical Opinion		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Second Opinion - Cancer		Unknown	Unknown	Unknown	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Physician Office Visits		Covered	Covered	Covered	Covered	Covered		Covered	Covered	Covered	Covered

DRAFT FOR DISCUSSION ONLY

Appendix A
New York State
Essential Health Benefits Study
Summary of Covered Services for Potential Benchmark Plans

	Affordable Care Act	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
									3 Largest Small Group Products		
TYPE OF SERVICE	**Identified as Essential Health Benefits**	**Basic Option**	**Standard Option**	**GEHA**	**Empire Plan**	**CDPHP**	**Independent Health**	**Largest non-Medicaid HMO (HIP Prime)**	**Oxford HMO**	**Oxford EPO**	**Oxford Direct**
Preventive & Primary Care: Adults	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered. **R** for changes due to ACA	Base Coverage and **R**.	Base Coverage and **R**.	Base Coverage and **R**.
- Routine exams		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Immunizations		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Bone Density Testing		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Prostate Cancer Screening		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Allergy Testing		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Mammography		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Cervical Cytology		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Preventive & Primary Care: Children	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered. **R** for changes due to ACA	Base Coverage and **R**.	Base Coverage and **R**.	Base Coverage and **R**.
- Well-child Care		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Immunizations/Vaccines		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Routine check-ups		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Chiropractic Services		Covered. One office visit per year, 12 manipulation visits per year	Covered. One office visit per year, 20 manipulation visits per year	Covered, 12 Office Visits per year	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Mastectomy, Lumpectomy, lymph node dissection		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Base Coverage and **R**.	Base Coverage and **R**.	Base Coverage and **R**.
Breast Reconstructive Surgery		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
External Mastectomy Prostheses		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Laboratory Services	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiology & Imaging Services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Ambulatory Patient Services (Awaiting HHS definition)	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Outpatient Surgical Services											
- Physician's Office		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Surgical Centers		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Chronic Disease Management	✓	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Eating Disorders - Comprehensive Care Centers		Dietary counseling covered	Dietary counseling covered	Dietary counseling covered	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements	Yes, subject to medical necessity and provider requirements	Covered	Covered	Covered	Covered
Diabetes Equipment, Supplies and Self Education		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

DRAFT FOR DISCUSSION ONLY

Appendix A
New York State
Essential Health Benefits Study
Summary of Covered Services for Potential Benchmark Plans

	Affordable Care Act	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
									3 Largest Small Group Products		
TYPE OF SERVICE	**Identified as Essential Health Benefits**	**Basic Option**	**Standard Option**	**GEHA**	**Empire Plan**	**CDPHP**	**Independent Health**	**Largest non-Medicaid HMO (HIP Prime)**	**Oxford HMO**	**Oxford EPO**	**Oxford Direct**
Durable Medical Equipment		Covered	Covered	Covered	Covered	Covered	Covered	Coverage available via **OR**	Covered by **R** for **s**tandard DME and medical supplies up to $1,500 per calendar year. **OR** with unlimited coverage available. Motorized equipment, electronic and neuromuscular stimulators, and myoelectric prosthesis are not covered benefits.	Covered by **R** for **s**tandard DME and medical supplies up to $1,500 per calendar year. **OR** with unlimited coverage available. Motorized equipment, electronic and neuromuscular stimulators, and myoelectric prosthesis are not covered benefits.	Covered by **R** for **s**tandard DME and medical supplies up to $1,500 per calendar year. **OR** with unlimited coverage available. Motorized equipment, electronic and neuromuscular stimulators, and myoelectric prosthesis are not covered benefits.
Prostheses		Covered	Covered	Covered	Covered	Covered	Covered	Coverage available via **OR**	Covered for Internal and External Prosthetic Devices.	Covered for Internal and External Prosthetic Devices.	Covered for Internal and External Prosthetic Devices.
Orthotics		Covered	Covered	Covered	Covered	Covered	Covered	Coverage available via **OR**	Not Covered	Not Covered	Not Covered
Habilitative Services (awaiting HHS definition)	✓										
Rehabilitation Services (Awaiting HHS definition)	✓							Covered with visit limits. The visit limits referenced below refer to a combined visit limit for OT, PT and SP.	Covered with visit limits. The visit limits referenced below refer to a combined visit limit for OT, PT and SP.	Covered with visit limits. The visit limits referenced below refer to a combined visit limit for OT, PT and SP.	Covered with visit limits. The visit limits referenced below refer to a combined visit limit for OT, PT and SP.
- Physical Therapy		Covered, 50 visits per calendar year for Physical, Occupational and Speech Therapy combined	Covered, 75 visits per calendar year for Physical, Occupational and Speech Therapy combined	Covered , 60 total Physical or Occupational Therapy visits per calendar year	Covered	Covered , 30 visits per calendar year	Covered, 20 PT/OT/ST visits combined per calendar year	Covered, Inpatient 90 days, Outpatient 90 days	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.
- Occupational Therapy		Covered, 50 visits per calendar year for Physical, Occupational and Speech Therapy combined	Covered, 75 visits per calendar year for Physical, Occupational and Speech Therapy combined	Covered , 60 total Physical or Occupational Therapy visits per calendar year	Covered	Covered , 30 visits per calendar year	Covered, 20 PT/OT/ST visits combined per calendar year	Covered, Inpatient 90 days, Outpatient 90 days	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.
- Speech Therapy		Covered, 50 visits per calendar year for Physical, Occupational and Speech Therapy combined	Covered, 75 visits per calendar year for Physical, Occupational and Speech Therapy combined	Covered , 30 visits per calendar year	Covered	Covered , 20 visits per calendar year	Covered, 20 PT/OT/ST visits combined per calendar year	Covered, Inpatient 90 days, Outpatient 90 days	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.

DRAFT FOR DISCUSSION ONLY

Appendix A
New York State
Essential Health Benefits Study
Summary of Covered Services for Potential Benchmark Plans

	Affordable Care Act	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
									3 Largest Small Group Products		
TYPE OF SERVICE	Identified as Essential Health Benefits	Basic Option	Standard Option	GEHA	Empire Plan	CDPHP	Independent Health	Largest non-Medicaid HMO (HIP Prime)	Oxford HMO	Oxford EPO	Oxford Direct
MENTAL HEALTH/SUBSTANCE ABUSE	✓										
Mental Health Treatment Services									**R**	**R**	**R**
- Inpatient Services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	**R**-- Covered, 30 inpatient days per calendar year. **OR--** unlimited MH coverage.	**R**-- Covered, 30 inpatient days per calendar year. **OR--** unlimited MH coverage.	**R**-- Covered, 30 inpatient days per calendar year. **OR--** unlimited MH coverage.
- Outpatient Services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered, **R** -- 30 outpatient visits per calendar year. This number includes office and facility visits.	Covered, **R** -- 30 outpatient visits per calendar year. This number includes office and facility visits.	Covered, **R** -- 30 outpatient visits per calendar year. This number includes office and facility visits.
Chemical Dependence Services											
- Inpatient Services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered, 30 days per calendar year.	Covered, 30 days per calendar year.	Covered, 30 days per calendar year.
- Outpatient Services		Covered	Covered	Covered	Covered, unlimited visits, up to 20 family counseling visits per calendar year	Covered	Covered, unlimited visits, up to 20 family counseling visits per calendar year	Covered	Covered, 60 visits, including 20 family counseling visits per calendar year. This number includes office and facility visits.	Covered, 60 visits, including 20 family counseling visits per calendar year. This number includes office and facility visits.	Covered, 60 visits, including 20 family counseling visits per calendar year. This number includes office and facility visits.
- Detoxification Services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered, 7 days of inpatient detoxification per calendar year.	Covered, 7 days of inpatient detoxification per calendar year.	Covered, 7 days of inpatient detoxification per calendar year.
- Rehab		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered, 7 days of inpatient detoxification per calendar year.	Covered, 7 days of inpatient detoxification per calendar year.	Covered, 7 days of inpatient detoxification per calendar year.
PRESCRIPTION DRUG BENEFITS	✓										
- Prescription Drugs		Covered	Covered	Covered	Covered	Covered with RX Rider	Covered with RX Rider	Coverage available via **OR** RX rider	Coverage available via **OR** RX rider	Coverage available via **OR** RX rider	Coverage available via **OR** RX rider
- Enteral Formula		Covered when prescribed	Covered when prescribed	Covered when prescribed	Covered when prescribed	Covered under RX Rider with prior approval	Covered under RX Rider with prior approval	Coverage provided under **OR** RX rider	Coverage provided under **OR** RX rider	Coverage provided under **OR** RX rider	Coverage provided under **OR** RX rider
- Off label Cancer Drugs		Unknown	Unknown	Unknown	Covered	Covered under RX Rider with prior approval	Covered under RX Rider with prior approval	Coverage provided under **OR** RX rider	Coverage provided under **OR** RX rider	Coverage provided under **OR** RX rider	Coverage provided under **OR** RX rider
- Non-Prescription Drugs		Not Covered	Not Covered	Not Covered except for some OTC Smoking cessation drugs	Not Covered	Not Covered	Not Covered	Not covered	Not covered	Not covered	Not covered

DRAFT FOR DISCUSSION ONLY

Appendix A
New York State
Essential Health Benefits Study
Summary of Covered Services for Potential Benchmark Plans

	Affordable Care Act	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
									3 Largest Small Group Products		
TYPE OF SERVICE	**Identified as Essential Health Benefits**	**Basic Option**	**Standard Option**	**GEHA**	**Empire Plan**	**CDPHP**	**Independent Health**	**Largest non-Medicaid HMO (HIP Prime)**	**Oxford HMO**	**Oxford EPO**	**Oxford Direct**
TRANSPORTATION SERVICES											
- Emergency Transportation (Ambulance)		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Emergency Transportation (Air Ambulance)		Covered	Covered	Covered, if medically necessary	Covered, if medically necessary	Covered, if medically necessary	Covered, if medically necessary	Covered if medically necessary	Covered	Covered	Covered
- Non-Emergency Transport		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not covered	Covered, non-emergent ambulance services (e.g. inter-facility transports, air or ground) covered if preauthorized.	Covered, non-emergent ambulance services (e.g. inter-facility transports, air or ground) covered if preauthorized.	Covered, non-emergent ambulance services (e.g. inter-facility transports, air or ground) covered if preauthorized.
VISION SERVICES	✓	(essential benefit for children)									
- Vision services related to specific medical condition		Covered	Covered	Covered	Not Covered	Covered when related to diabetes	Covered	Covered	Covered	Covered	Covered
- Routine Vision Services		Coverage available through **OR**.	Coverage available through **OR**.	Coverage for 1 routine vision exam per year	Not Covered	Covered, one vision screening examination (without refraction) within a 12 month period. This screening is performed by the PCP for both children and adults.	Covered, 1 refractive exam every 12 months	Coverage available via **OR** Optical rider	Covered, one vision screening examination (without refraction) within a 12 month period. This screening is performed by the PCP for both children and adults. **OR**-$50 reimbursement every 12 months for a comprehensive exam including refraction.	Covered, one vision screening examination (without refraction) within a 12 month period. This screening is performed by the PCP for both children and adults. **OR**-$50 reimbursement every 12 months for a comprehensive exam including refraction.	Covered, one vision screening examination (without refraction) within a 12 month period. This screening is performed by the PCP for both children and adults. **OR**-$50 reimbursement every 12 months for a comprehensive exam including refraction.
Appliances (e.g. glasses and contact lenses)		Coverage available through **OR**.	Coverage available through **OR**.	Coverage available through **OR**.	Not Covered	Not Covered	Covered	Coverage available via **OR** Optical rider	**OR**--Groups that purchase the vision rider may also purchase a $70-200 benefit for one set of appliances.	**OR**--Groups that purchase the vision rider may also purchase a $70-200 benefit for one set of appliances.	**OR**--Groups that purchase the vision rider may also purchase a $70-200 benefit for one set of appliances.
DENTAL SERVICES	✓	(essential benefit for children)									
- Emergency Dental Services (e.g., treatment of accidental injuries to sound, natural teeth)		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Routine Dental Services		Covered, two exams/cleanings per year	Covered, two exams/cleanings per year, x-rays, restorations/simple extractions	Covered, two exams/cleanings per year and restorations/simple extractions	Covered	Covered	Covered	Not covered	Covered by **OR**. There are 2 levels of coverage and Oxford has a provider network in place for dental services.	Covered by **OR**. There are 2 levels of coverage and Oxford has a provider network in place for dental services.	Covered by **OR**. There are 2 levels of coverage and Oxford has a provider network in place for dental services.
Oral Surgery (inpatient and outpatient)		Covered, oral or maxillofacial surgery for specific conditions listed	Covered, oral or maxillofacial surgery for specific conditions listed	Covered, oral or maxillofacial surgery for specific conditions listed	Covered	Covered	Covered	Not covered	Covered	Covered	Covered

DRAFT FOR DISCUSSION ONLY

Appendix A
New York State
Essential Health Benefits Study
Summary of Covered Services for Potential Benchmark Plans

	Affordable Care Act	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
									3 Largest Small Group Products		
TYPE OF SERVICE	Identified as Essential Health Benefits	Basic Option	Standard Option	GEHA	Empire Plan	CDPHP	Independent Health	Largest non-Medicaid HMO (HIP Prime)	Oxford HMO	Oxford EPO	Oxford Direct
OTHER SERVICES											
Hearing Related Services											
- Testing		Children are covered. Adults are only covered when related to illness, injury, or when related to prescribing or fitting hearing aids.	Children are covered. Adults are only covered when related to illness, injury, or when related to prescribing or fitting hearing aids.	Children are covered. Adults are only covered when related to illness, injury, or when related to prescribing or fitting hearing aids.	Not Covered	Covered	Covered	Covered	Covered for Children**. R**--Covered for adults.	Covered for Children. **R**--Covered for adults.	Covered for Children. **R**--Covered for adults.
- Hearing Aids		Covered, $1,500 every 3 years for adults, $1,500 per year for children	Covered, $1,500 every 3 years for adults, $1,500 per year for children	Covered	Covered, up to $1,500 per aid/ear every 4 years	Not Covered	Not Covered	Not covered	**R--**Covered. Coverage for hearing aids is limited to (a) $1500 and (b) a single purchase including repair and replacement every 3 years. **OR**--coverage available up to $5,000.	**R--**Covered. Coverage for hearing aids is limited to (a) $1500 and (b) a single purchase including repair and replacement every 3 years. **OR**--coverage available up to $5,000.	**R--**Covered. Coverage for hearing aids is limited to (a) $1500 and (b) a single purchase including repair and replacement every 3 years. **OR**--coverage available up to $5,000.
- Cochlear Implants		Covered	Covered	Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered
Infertility Services									**R and OR**	**R and OR**	**R and OR**
- Diagnosis and treatment of infertility		Covered, limited to $3,000 per person per calendar year	Covered	Covered	Covered	Covered	Covered	Covered per NYS Mandate	**R**--Covered for basic infertility services.	**R**--Covered for basic infertility services.	**R**--Covered for basic infertility services.
- Assisted reproductive technology procedures		Not Covered	Not Covered	Not Covered	Covered, if approved as a Qualified Procedure by UHC up to $50,000 lifetime	Only Artificial Insemination covered	Not Covered	Artificial Insemination covered	Not covered	Not covered	Not covered
Family Planning/ Reproductive Health Services											
- Contraceptives		Covered	Covered	Covered	Covered	**R**--Covered	**R**--Covered	Covered	**R**--Covered	**R**--Covered	**R**--Covered
- Voluntary sterilization		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Abortion (medically necessary)		Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.	Covered	Covered	Covered	Covered	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.
- Abortion (elective)		Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered	May be covered for elective abortions subject to benefit limits. Benefits may be excluded for based on religion.	May be covered for elective abortions subject to benefit limits. Benefits may be excluded for based on religion.	May be covered for elective abortions subject to benefit limits. Benefits may be excluded for based on religion.

DRAFT FOR DISCUSSION ONLY

Appendix A
New York State
Essential Health Benefits Study
Summary of Covered Services for Potential Benchmark Plans

	Affordable Care Act	Federal Health Benefit Plans			NYS Employee Plans (NYSHIP)			Commercial Plans			
									3 Largest Small Group Products		
TYPE OF SERVICE	**Identified as Essential Health Benefits**	**Basic Option**	**Standard Option**	**GEHA**	**Empire Plan**	**CDPHP**	**Independent Health**	**Largest non-Medicaid HMO (HIP Prime)**	**Oxford HMO**	**Oxford EPO**	**Oxford Direct**
Foot Care Services											
- Foot Care related to a specific medical condition		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Routine Foot Care (Such as cutting, trimming, or removal of corns, calluses, etc.)		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not covered	Not covered	Not covered
- Foot Orthotics / Shoe Inserts		Covers functional foot orthotics when prescribed by a physician	Covers functional foot orthotics when prescribed by a physician	Not Covered	Covers functional foot orthotics when prescribed by a physician	Not Covered	Not Covered	Not Covered	Not covered.	Not covered.	Not covered.
Organ Transplants		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Smoking Cessation		Covered	Covered	Covered	Prescription aids covered in prescription drug benefit	Up to 4 physician visits per year, prescription (generics only) and over the counter drugs if physician prescribed, limited to 2 12-week cycles per year	Program includes telephonic counseling, smoking cessation classes and over the counter and prescribed drugs, limited to 1 6-month course of treatment per year	Covered	Not specifically covered. Some services may be covered under the base coverage (e.g. counseling) and prescription drug coverage may be available under the prescription drug rider.	Not specifically covered. Some services may be covered under the base coverage (e.g. counseling) and prescription drug coverage may be available under the prescription drug rider.	Not specifically covered. Some services may be covered under the base coverage (e.g. counseling) and prescription drug coverage may be available under the prescription drug rider.
Misc. Services											
-Allergy Shots		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
- Acupuncture		Covered	Covered, up to 24 visits per year	Covered, limit of 20 procedures per year (medically necessary by MD or DO)	Not Covered	Covered for emesis after surgery or chemotherapy or for persistent nausea in pregnancy	Covered through wellness account	Not Covered	**OR**	**OR**	**OR**
- Weight Loss Programs		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
- Gym membership		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered through wellness account	Not Covered	**OR.** If a member completes 50 gym visits within a 6-month period, then Oxford will reimburse $200. If the member's spouse (or Domestic Partner if the Group has purchased this coverage) completes 50 gym visits within a 6-month period, then Oxford will reimburse $100.	**OR.** If a member completes 50 gym visits within a 6-month period, then Oxford will reimburse $200. If the member's spouse (or Domestic Partner if the Group has purchased this coverage) completes 50 gym visits within a 6-month period, then Oxford will reimburse $100.	**OR.** If a member completes 50 gym visits within a 6-month period, then Oxford will reimburse $200. If the member's spouse (or Domestic Partner if the Group has purchased this coverage) completes 50 gym visits within a 6-month period, then Oxford will reimburse $100.
Autism Spectrum Disorders (Effective Nov. 1, 2012)		Does not cover ABA services	Does not cover ABA services	Does not cover ABA services	Will be covered	Will be covered	Will be covered	Will be covered	Will be covered	Will be covered	Will be covered

ABA determination for autism based on CCIIO Bulletin on December 16, 2011, page 5.