Exhibit D.1. Summary of Comparative Analysis of EHB Benchmark Plans

Services	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Ambulatory Patient Services				
Primary Care Visit to Treat an Injury or Illness	Y	Y	Y	Y
Specialist Visit	Y	Y	Y	Y
Other Practitioner Office Visit (Nurse, Physician Assistant)	Y	Y	Y	Y
Outpatient Surgery Physician/Surgical Services	Y	Y	Y	Y
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Y	Y	Y	Y
Home Health Care Services	100 visits	80 visits	100 visits	200 visits (inc. max. of 80 home health aid visits)
Skilled Nursing Facility	90 days	30 days	90 days	unlimited
Emergency Services				
Emergency Room Services	Y	Y	Y	Y
Emergency Transportation/Ambulance	Y	Y	Y	Y
Urgent Care Centers or Facilities	Y	Y	Y	Y
Hospitalization				
Inpatient Hospital Services	Y	Y	Y	Y
Inpatient Physician and Surgical Services	Y	Y	Y	Y
Skilled Nursing Facility	Y 30 days/condition upto 90 days/year	Y 30 days/year	Y 90 days/year	unlimited
Rehabilitation Facilities	Y 60 consecutive days/year	Y	Y 90 days/year combined with SNF	unlimited
Home Health Care Services (1 visit = 4 hours)	Y 100 visits/year	Y 80 visits/year	Y 100 visits/year	Y 200 visits/year
Home Health Aids (count toward Home Health Care services limit)	Y 80 visits/year	Y	Y	Y 80 visits/year
Hospice	Y 90 days	Y unlimited with life expectancy < 6 mon	Y unlimited with life expectancy < 6 mon	Y IN: unlimited OON: 60 days
Maternity and Newborn Care				
Prenatal and Postnatal Care	Y	Y	Y	Y
Delivery and All Inpatient Services for Maternity Care	Y	Y	Y	Y
Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment				
Mental/Behavioral Health Inpatient Services	Y	Y	Y	Y
Mental/Behavioral Health Outpatient Services*	Y	Y	Y	Y
Substance Abuse Disorder Inpatient Services	Y	Y	Y	Y
Substance Abuse Disorder Outpatient Services	Y	Y	Y	Y
Prescription Drugs				
Three Tier Drug Formularly	rider	rider	rider	rider
Specialty Drug Tier				
Rehabilitative and Habilitative Services and Devices				
Outpatient Rehabilitation Services (PT/OT/ST)	30 visits	20 visits	40 visits	unlimited
Chiropratic Visits	20 visits	20 visits	20 visits	unlimited
Habilitation Services	autism coverage	autism coverage	autism coverage	autism coverage
Durable Medical Equipment	Y	Y	Y	Y
Laboratory Services				
Diagnostic Test (X-Ray and Laboratory Tests)	Y	Y	Y	Y
Imaging (CT and PET Scans, MRIs)	Y	Y	Y	Y
Preventive and Wellness Services and Chronic Disease Management				
Preventive Care/Screening/Immunization	Y	Y	Y	Y
Pediatric Services, Including Oral and Vision Care				
Dental Check-Up for Children	Y	N	Y	Y
Vision Screening for Children	$45 copay	$0 copay	Y (vision rider)	$15 copay
Eye Glasses for Children	Y	N	N	N

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Ambulatory Patient Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Ambulatory Patient Services				
PROVIDERS				
Primary Care Providers	Y	Y	Y	Y
Family/General	Y	Y	Y	Y
Internal Medicine	Y	Y	Y	Y
OB/Gyn	Y	Y	Y	Y
Specialist Physicians	Y	Y	Y	Y
Other Covered Providers				
Nurse Midwife	Y	Y	Y	Y
Chiropractor	Y 20 visits/year	Y 20 visits/year	Y 20 visits/year	Y IN: unlimited OON: 30 visits/year
Osteopath	Y	Y	unknown	Y
Acupuncturist	Y	N	N	N
Naturopath	Y	Y	Y	Y
Audiologist	Y	Y	Y	Y
Nurse Anesthesiologist	Y	Y	Y	Y
Physician Assistant	Y	Y	Y	Y
Certified Surgical Assistant	Y	Y	Y	Y
Optometrist	Y	Y	Y	Y
Nurse Practitioner/Clinical Specialist	Y	Y	Y	Y
Christian Science Practitioner	unknown	unknown	unknown	unknown
Biofeedback	N	N	N	unknown
Hypnotherapy	unknown	N	N	unknown
Clinical Ecology	unknown	unknown	unknown	unknown
Environmental Medicine	unknown	unknown	unknown	unknown
SERVICES				
Outpatient Surgery Physician/Surgical Services	Y	Y	Y	Y
Operative Procedures	Y	Y	Y	Y
Treatment of Fractures, Including Casting	Y	Y	Y	Y
Correction of Amblyopia and Strabismus	Y	Y	unknown	Y* orthoptics are covered for convergence insufficiency and amblyopia
Endoscopy Procedures	Y	Y	Y*	Y
Biopsy Procedures	Y	Y	Y*	Y
Removal of Tumors and Cysts	Y	Y	Y	Y
Voluntary Sterilization	Y reversal not covered	Y reversal not covered	Y reversal not covered	Y reversal not covered
Surgically Implanted Contraceptives	Y	Y	Y	Y must be performed during annual well woman visit
Treatment of Burns	Y	Y	Y	Y
Pre-Surgical Testing	Y	Y	Y	Y
Anesthesia	Y	Y	Y	Y
Physician Services	Y	Y	Y	Y
Office Medical Consultations	Y	Y	Y	Y

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Ambulatory Patient Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Infertility Diagnosis	Y	Y	Y	Y
Infertility Treatment	Y	Y	Y	Y
Pharmacotherapy	N* inpatient Rx only	N* inpatient Rx only	N* inpatient Rx only	N* inpatient Rx only
Second Surgical Opinions	Y	Y	unknown	Y
Telehealth	unknown	unknown	unkonwn	unknown
Breast Implant Removal (implanted before on 7/1994)	Y	Y	Y	Y
Separately Billed OP Facility Services				
Routine Vision Exams	Y* covered under Blue ViewVision	Y 1 exam/2 years	Y 1 exam/year	Y IN: 1 exam/year; OON: 1 exam/2 years
Routine Hearing Exams	Y	Y	N* only through age 19	Y 1 exam/year
Operating, Recovery/Observation and Other Treatment Rooms	Y	Y	Y	Y
Chemotherapy/Radiation Therapy	Y	Y	Y	Y
IV/Infusion Therapy	Y	Y	Y	Y
Dialysis	Y	Y	Y	Y
Respiratory/inhalation therapy	Y	Y	Y	Y
Medical Supplies, Including Oxygen	Y	Y	Y	Y
Dental - Diagnostic/Preventive	N	N	N	N
Dental - Restorative	N	N	N	N*
Routine Foot Care	N except for diabetics	N except for diabetics	N except for diabetics	N except for diabetics
Birthing Center	Y	unknown	Y	Y

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Emergency Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Emergency Services				
PROVIDERS				
Emergency Room Services	Y	Y	Y	Y
Emergency Transportation/Ambulance	y	Y	Y	Y
Local Ambulance	Y	Y	Y	Y
Air Ambulance	Y	Y	Y	Y
Urgent Care Centers or Facilities	Y	Y	Y	Y
Outside Hospital (Paramedics Care, Mobile Field Hospital, etc.)	Y	Y	Y	Y
SERVICES				
Outpatient Physician Care	Y	Y	Y	Y
Non-Surgical Physician Services and Supplies	Y	Y	Y	Y
Surgical Care	Y	Y	Y	Y

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Hospitalization)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Hospitalization				
PROVIDERS				
Inpatient Hospital Services (e.g. Hospital Stay) Providers	Y	Y	Y	Y
Inpatient Non-Hospital				
Skilled Nursing Facility	Y 30 days/condition upto 90 days/year	Y 30 days/year	Y 90 days/year	unlimited
Rehabilitation Facilities	Y 60 consecutive days/year	Y	Y 90 days/year combined with SNF	unlimited
Home Health Care Services (1 visit = 4 hours)	Y 100 visits/year	Y 80 visits/year	Y 100 visits/year	Y 200 visits/year
Home Health Aids (count toward Home Health limits)	Y 80 visits	Y	Y	Y 80 visits/year
Hospice	Y 90 days	Y	Y unlimited with life expectancy < 6 mon	Y unlimited with life expectancy < 6 mon
SERVICES				
Inpatient Surgical Services				
Reconstructive Surgery (Excluding Cosmetic)	Y	Y	Y	Y
Obesity Surgery	N	N	N	unknown
Temporomandibular disorders (TMD)	N	N	Y* surgical treatment only	Y* surgical treatment only
Transplants - Human Organ/Tissue	Y	Y	Y	Y
Transplants - Artificial Organ Implant	Y	Y	unknown	N
Correction of Congenital Anomalies	Y	Y	Y	Y
Insertion of Internal Prosthetic Devices	Y	Y	Y	Y
Anesthetics	Y	Y	Y	Y
Inpatient Physician/Other Services				
Physician Visits	Y	Y	Y	Y
Nursing	Y	Y	Y	Y
Administration of Blood, Plasma, and other Biologicals	Y	Y	Y	Y
Medical Supplies	Y	Y	Y	Y
Pre-Admission Testing	Y	Y	Y	Y
Hospice Specific Services				
Dietary Counseling	Y	Y	Y*	unknown
Durable Medical Equipment	Y	Y	Y*	Y*
Medical Social Services (Counseling)	Y	Y	Y	Y 5 visits
Private Duty Nursing	N	N	Y*	Y
Oxygen Therapy	Y	Y	Y*	Y
Respite Care	unknown	unknown	unknown	N

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Maternity and Newborn Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Maternity and Newborn Care				
PROVIDERS				
Inpatient Hospital Providers	Y	Y	Y	Y
OB/Gyn	Y	Y	Y	Y
Nurse Midwife	Y	Y	Y	Y
Lactation Consultant (mandated service)	Y 1 home visit with early discharge	Y 1 home visit with early discharge	Y 1 home visit with early discharge	Y 1 home visit with early discharge
Birthing Center	Y	unknown	Y	Y
Home Birth	N	N	N	unknown
SERVICES				
Prenatal Care				
Childbirth Classes	unknown	unknown	unknown	unknown
Laboratory/Diagnosis	Y	Y	Y	Y
Ultrasound	Y	Y	Y	Y
Tocolytic Therapy	unknown	unknown	unknown	unkonwn
Postnatal Care				
Breastfeeding Education	Y	Y	Y 1 home visit	y
Mental Health Treatment for Postpartum Depression (Mental Health Parity)	Y	Y	Y	Y
Delivery and Inpatient Services for Maternity				
Delivery	Y	Y	Y	Y
Nursery Care	Y	Y	Y	Y
Termination of Pregnancy				
Therapeutic	Y	Y	Y	Y
Non-therapeutic in case of rape/incest	Y	Y	Y	Y
Non-therapeutic in case of fetal malformation	Y	Y	unknown	Y
Elective	Y	unknown	unknown	Y 1/year

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Mental Health and Substance Use Disorder Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Mental Health and Substance Use Disorder Services				
PROVIDERS				
Psychiatry	Y	Y	Y	Y
Psychology	Y	Y	Y	Y
Clinical Social Worker	Y	Y	Y	Y
Professional Counselor	Y	Y	Y	Y
Marriage and Family Therapist	Y	Y	Y	Y* marital counseling not covered
SERVICES				
Mental/Behavioral Health Inpatient Services				
Pharmacotherapy	Y* mental health parity	Y* mental health parity	Y* mental health parity	Y* mental health parity
Psychological Testing (for conditions defined by American Psychiatric Association)	Y	Y	Y	Y
Electroconvulsive Therapy	Y	unknown	Y*	Y
Mental/Behavioral Health Outpatient Services				
Office Visits	Y	Y	Y	Y prior auth. required after 20 visits
Pharmacotherapy (probably covered under Rx services)	rider	rider	rider	rider
Psychological Testing	Y	Y	Y	Y excludes testing for learning disabilities or mental retardation
Crisis Intervention/Acute Stabilization	Y	Y	Y	Y*
Electroconvulsive Therapy	Y	unknown	Y*	Y*
Substance Abuse Disorder Inpatient Services				
Diagnosis and Treatment	Y	Y	Y	Y
Detoxification and Counseling	Y	Y	Y	Y*
Substance Abuse Disorder Outpatient Services				
Diagnosis and Treatment	Y	Y	Y	Y
Detoxification and Counseling	Y	Y	Y	Y*

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Prescription Drugs)

Service	Small Group Plans			State Employee Plans
	Anthem BCBS HMO	Aetna HMO	Largest Non-Medicaid HMO ConnectiCare HMO	Anthem State Preferred HMO
Prescription Drugs				
PROVIDERS	Rx provided through rider	Rx provided through rider	Rx provided through rider	Rx provided through rider
Mail Order Service				
Retail Service				
SERVICES				
Generic/Brand Drugs				
Specialty Drugs (involving Special Handling, Admin., Monitoring)				
Contraceptive Drugs				
Insulin and Needles for Diabetics	Y	Y	Y	Y

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Rehabilitative and Habilitative Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Rehabilitative and Habilitative Services				
PROVIDERS				
Licensed Phyiscal/Occupational/Speech Therapist	Y	Y	Y	Y
Physician	Y	Y	Y	Y
Skilled Nursing Facility	Y 30 days/condition upto 90 days/year	Y 30 days/year	Y 90 days/year	unlimited
Inpatient (IP) Rehabilitation Facility	Y 60 consecutive days/year * ***may*** *be subject to SNF limit*	unknown	Y 90 days/year **combined with SNF limits*	unlimited
Outpatient (OP) Rehabilitation Facility	Y 30 visits/year	Y 20 visits/year	Y 40 visits/year	unlimited
Massage Therapist	N*	N*	N*	unknown
SERVICES				
Rehabilitation Services				
Skilled Nursing Services	Y 30 days/condition upto 90 days/year	Y 30 days/year	Y 90 days/year	unlimited
Physical Therapy/Occupational Therapy/Speech Therapy[1] (PT/OT/ST)	Y IP: 60 consecutive days/condition (lifetime limit); OP: 30 visits/year	Y IP: unknown OP: 20 combined visits/year	Y SNF/IP: 90 days/year OP: 40 combined visits/year	Y IN: unlimited; OON: 30 visits/year
Chiropractic Services	Y 20 visits/year	Y 20 visits/year	Y 20 visits/year	Y IN: unlimited OON: 30 visits/year
Cognitive Rehabilitation Therapy	N* *YES to autism-related services*	Y 20 visits/year (combined with PT/OT/ST OP visits)	N* *YES to autism-related services*	N* *YES to autism-related services*
Cardiac Rehab	Y	Y	Y* Phase IV not covered	Y
Massage Therapy	unknown	unknown	N* only when part of PT/OT program	unknown
Maintenance/Palliative Rehabilitation Therapy	unknown	unknown	Y* pain management covered	Y* pain management covered
Habilitation Services[2]				
PT/OT/ST	unknown	unknown	unknown	unknown
Austism Spectrum Disorder				
Behavioral Therapy	Y	Y	Y	Y
Outpatient Rehabilitation *(PT/OT/ST limits don't apply per mandate)*	Y	Y	Y	Y

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Rehabilitative and Habilitative Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Durable Medical Equipment, Prosthetics				
Oxygen Equipment	Y	Y	Y	Y
Wheelchairs, Crutches, Walkers	Y	Y	Y	Y*
Home Dialysis Equipment	Y	Y	unknown	Y
Hearing Aids	Y children to age 12 only	Y children to age 12 only	Y children to age 12 only	Y children to age 12 only
Glasses/Contacts	N	N	N	N
Exercise Equipment for Medically Necessary Condition	N	N*	N	N
Artificial Limbs and Eyes	Y	Y	Y	Y
Repair/Maintenance of Approved Prosthetics	Y	Y	Y	Y excludes repair/replace due to misuse/loss
Orthotics	N* medically necessary only	N	N* only if diabetic	N* medically necessary only
Wigs for Hair Loss due to Chemotherapy	Y	Y	Y	Y
Wound Care (for Epidermoysis Bullosa)	Y	Y	Y	Y
Ostomy Supplies	Y	Y	Y	Y
Hypodermic Needles	Y	Y	Y	Y
Breast Implants (following mastectomy)	Y	Y	Y	Y
Diabetic Equipment and Supplies	Y	Y	Y	Y

Notes:

1. Speech Therapy limited to autism, stroke, tumor removal, or injury or congenital anomalies to oropharynx
2. For all plans, "habilitative" not clearly spelled out in existing plan documentation.

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Laboratory Services)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Laboratory Services				
PROVIDERS				
Laboratory	Y	Y	Y	Y
Inpatient Facility	Y	Y	Y	Y
Outpatient Facility	Y	Y	Y	Y
Physician	Y	Y	Y	Y
Radiologists	Y	Y	Y	Y
SERVICES				
Electrocardiograms (EKGs) Laboratory/Blood Tests	Y	Y	Y 1 test/year	Y
Neurological Testing	Y	Y	Y	Y*
Pathology Services	Y	Y	Y*	Y
Urinalysis	unknown	unknown	Y 1 test/year	Y
X-Rays	Y	Y	Y	Y
Electroencephalograms (EEGs)	Y	Y	Y	Y
Ultrasounds	Y	Y	Y	Y
CT scans/MRIs, PET Scans	Y	Y	Y	Y
Bone Density Tests	Y	Y	Y	Y
Diagnostic Angiography	Y	Y	Y	Y
Genetic Testing - Diagnostic	Y	Y	Y	Y
Nuclear Medicine	Y	Y	Y	Y
Polysomnography (Sleep Studies)	Y	Y	Y	Y

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Preventive and Wellness Services and Chronic Disease Management)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Preventive and Wellness Services and Chronic Disease Management				
PROVIDERS				
Primary Care Provider	Y	Y	Y	Y
OB/Gyn	Y	Y	Y	Y
SERVICES				
Preventive Care/Screenings for Adults				
Adult Physical Exam	Y 1 visit/year	Y as recommended	Y ages 22-49: 1 visit/1-3 years aged 50-64: 1 visit/year	Y 1 visit/year
Routine Eye Exam	Y 1 exam/2 years; **with ViewVision: 1 exam/year*	Y 1 exam/2 years	N* Diabetics Only: 1 exam/year	Y 1 exam/year
Routine Gynecological Visit	Y	Y	Y	Y 1 visit/year
Nutritional Counseling	Y	Y	Y 2 visits/year	Y 3 visits/year
Smoking Cessation Program	Y	Y	Y	Y
Health Risk Education/Counseling	Y	Y	unknown	unknown
Cancer Screening (Prostate, Breast, Colorectal, Cervical)	Y	Y	Y	Y
Mammography (1 baseline for age 35-39; 1 screening/year for 40+)	Y	Y	Y	Y
Cholesterol Screening	Y	Y	Y	Y
STI Screening	Y	Y	Y/N 1 Chlamydia, Syphilis, or Gonorrhea screening/year (females only); unlimited HIV testing	unknown
Osteoporosis Screening	Y	Y	Y	Y
CDC Recommended Immunizations	Y	Y	Y	Y
Diabetes Education	Y	Y	Y	Y
Metabolic Panel	Y	Y	Y 1 test/year	Y
Genetic Counseling and Screening	Y	Y	Y BRCA counseling and genetic screening for women at risk	Y
Preventative Care/Screenings for Children				
Well Child Care	Y	Y	Y	Y
CDC Recommended Immunizations	Y	Y	Y	Y
STI Screening	Y	Y	Y	unknown
Other Services				
Allergy Testing and Treatment	Y 80 visits/3 years	Y	Y $315/2 years	Y
Modified Food Products for Inherited Metabolic Diseases	Y	Y	Y	Y
Lyme Disease Treatment	Y	Y	Y	Y
Insulin and Needles for Diabetics	Y	Y	Y	Y

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered

Exhibit D.2. Comparative Analysis of EHB Benchmark Plans (Pediatric Services, including Oral and Visions)

Service	Small Group Plans			State Employee Plans
			Largest Non-Medicaid HMO	
	Anthem BCBS HMO	Aetna HMO	ConnectiCare HMO	Anthem State Preferred HMO
Pediatric Services (Including Oral and Vision Care)				
PROVIDERS				
Pediatrician	Y	Y	Y	Y
Other Primary Care Provider	Y	Y	Y	Y
SERVICES				
Preventative Care/Screenings for Children				
Well Child Care[1]	Y	Y	Y	Y
CDC Recommended Immunizations	Y	Y	Y	Y include immunizations for travelling
STI Screening	Y	Y	Y	unknown
Dental Check-Up for Children	N	N	N	N
Vision Screening for Children	Y 1 exam/2 years	Y frequency not specified	Y 1 exam/year	Y 1 exam/year
Eye Glasses for Children	N *with Blue ViewVision:* lenses: $20 copay frame: $120/2 years OR, contacts: $105/year	N	N	N
Hearing Screening for Children	Y	Y	Y	Y
Modified Foods for Inherited Metabolic Diseases	Y	Y	Y	Y
Blood Lead and Screening	Y	Y	Y children up to 6	Y

Notes:

1. Well Child Care visits include: 6 exams from birth to 1; 6 exams 1 through 5 years of age; 1 exam every year calendar year year 6 through 21

Legend: Y = Covered, N = Not Covered, Y* = Probably Covered, N* = Probably Not Covered