VIRGINIA 2017 EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Small Group Market
Issuer Name	Anthem Health Plans of Virginia (Anthem BCBS)
Product Name	PPO Off Exchange
Plan Name	Premier DirectAccess PPO
Supplemented Categories (Supplementary Plan Type)	Pediatric dental (CHIP)

BENEFITS AND LIMITS

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No			Non-interactive telemedicine services.	Including doctor visits in the home and online visits.
Specialist Visit	Yes	Covered	No			Non-interactive telemedicine services.	
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No			Non-interactive telemedicine services.	Includes Retail Health Clinics (walk-ins).
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No			Removal of wisdom teeth. Eye surgery to fix errors of refraction, such as near-sightedness, including, but not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy. Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis. Services to reverse elective sterilization; services or supplies for male or female sexual problems; services and supplies for a sex change and/or the reversal of a sex change.	Includes coverage for blood and blood products, anesthesia and anesthesia supplies and services given by the Hospital or other Facility, medical and surgical dressings and supplies, casts, and splints. Includes coverage for general anesthesia and hospitalization services when determined by dentist and treating physician that such services are required to effectively and safely provide dental care for (i) children under the age of 5, (ii) covered persons who are severely disabled, or (iii) covered persons who have a medical condition that requires admission to a hospital or Outpatient surgery facility. Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children; other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine; endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; treatment of fractures and dislocations; anesthesia and surgical support when Medically Necessary; Medically Necessary pre-operative and post-operative care. Benefits are limited to certain oral surgeries including: treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy when related to tooth extraction; orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the affected part; oral / surgical correction of accidental injuries; surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; treatment of non-dental lesions, such as removal of tumors and biopsies; incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses. Includes surgical treatment of injuries and illnesses of the eye.

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Outpatient Surgery Physician/Surgical Services	Yes	Covered	No			Removal of wisdom teeth. Eye surgery to fix errors of refraction, such as near-sightedness, including, but not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy. Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses. Services to reverse elective sterilization; services or supplies for male or female sexual problems; services and supplies for a sex change and/or the reversal of a sex change.	Includes coverage for blood and blood products, anesthesia and anesthesia supplies and services given by the Hospital or other Facility, medical and surgical dressings and supplies, casts, and splints. Includes coverage for general anesthesia and hospitalization services when determined by dentist and treating physician that such services are required to effectively and safely provide dental care for (i) children under the age of 5, (ii) covered persons who are severely disabled, or (iii) covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children; other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine; endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; treatment of fractures and dislocations; anesthesia and surgical support when Medically Necessary; Medically Necessary pre-operative and post-operative care. Benefits are limited to certain oral surgeries including: treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy when related to tooth extraction; orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the affected part; oral / surgical correction of accidental injuries; surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; treatment of non-dental lesions, such as removal of tumors and biopsies; incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses. Includes surgical treatment of injuries and illnesses of the eye.

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Hospice Services	Yes	Covered	No				Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Skilled nursing services, home health aide services, and homemaker/custodial care services given by or under the supervision of a registered nurse. Social services and counseling services from a licensed social worker. Nutritional support such as intravenous feeding and feeding tubes. Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist. Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of your condition, including oxygen and related respiratory therapy supplies. Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	No	Not Covered	No			Assisted reproductive technologies (ART) such as artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT) are NOT covered.	Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	Yes	16	Hours per Benefit Period	Coverage does not include benefits for private duty nursing in the inpatient setting.	
Routine Eye Exam (Adult)	No	Covered	Yes	1	Exam(s) per Benefit Period		
Urgent Care Centers or Facilities	Yes	Covered	No				Includes X-ray services; Care for broken bones; Tests such as flu, urinalysis, allergy test, pregnancy test, rapid strep; Lab services; Stitches for simple cuts; and Draining an abscess.
Home Health Care Services	Yes	Covered	Yes	100	Visit(s) per Benefit Period	Manipulation Therapy which will not be covered when given in the home; Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider; Food, housing, homemaker services and home delivered meals.	Visit limit does not apply to home infusion therapy or home dialysis. The Home Care visit limit will apply instead of the Therapy Services limits for physical, occupational, speech therapy, or cardiac rehabilitation for therapy in the home. Benefit includes intermittent skilled nursing services by an R.N. or L.P.N.; Medical / social services; Diagnostic services; Nutritional guidance; Training of the patient and/or family/caregiver; Home health aide services; Therapy Services; Medical supplies; Durable medical equipment.
Emergency Room Services	Yes	Covered	No				Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for a medical emergency.

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Emergency Transportation/Ambulance	Yes	Covered	No			Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home. Coverage is not available for air ambulance transfers for the reason of being treated in a specific Hospital or by a specific Physician.	Includes medically necessary transportation to the nearest appropriate hospital for a medical emergency, or between hospitals or other approved facilities. Includes ground, water, fixed wing and rotary air transportation. Benefits also include medically necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a facility. Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				Benefits for room, board, and nursing services include: a room with two or more beds; a private room when medically necessary for isolation and no isolation facilities are available; a room in an approved special care unit; meals, special diets; general nursing services; operating, childbirth, and treatment rooms and equipment; prescribed drugs; anesthesia, anesthesia supplies and services given by the hospital or other provider; medical and surgical dressings and supplies, casts, and splints; blood and blood products; diagnostic services. Includes coverage for general anesthesia and hospitalization services when determined by dentist and treating physician that such services are required to effectively and safely provide dental care for (i) children under the age of 5, (ii) covered persons who are severely disabled, or (iii) covered persons who have a medical condition that requires admission to a hospital or Outpatient surgery facility.

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Inpatient Physician and Surgical Services	Yes	Covered	No			Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.	Includes medical care visits; intensive medical care when medically necessary; treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery; treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors; a personal bedside exam by another Doctor when asked for by your Doctor; surgery and general anesthesia; professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology. Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children; other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine; endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; treatment of fractures and dislocations; anesthesia and surgical support when medically necessary; medically necessary pre-operative and post-operative care. Medical benefits are limited to certain oral surgeries including: treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy when related to tooth extraction; orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is medically necessary to attain functional capacity of the affected part; oral / surgical correction of accidental injuries; surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; treatment of non-dental lesions, such as removal of tumors and biopsies; incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses. Includes surgical treatment of injuries and illnesses of the eye.
Bariatric Surgery	No	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	100	Day(s) per Stay	Custodial care even if it is recommended by a professional or performed in a facility, such as a Skilled Nursing Facility.	Includes room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies. Your Plan will cover the private room charge when medically necessary.
Prenatal and Postnatal Care	Yes	Covered	No				Includes prenatal and postnatal services for the mother; postnatal services for the baby, including hemoglobinopathies screening; gonorrhea prophylactic medication; hypothyroidism screening, PKY screening and Rh incompatibility testing.

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Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				Includes services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include: pregnancy testing; professional and facility services for childbirth including use of the delivery room and care for normal deliveries, in a facility or the home including the services of an appropriately licensed nurse midwife; anesthesia services to provide partial or complete loss of sensation before delivery; routine nursery care for the newborn during the mother's normal hospital stay, including circumcision of a covered male dependent; allowed fetal screenings, which are genetic or chromosomal tests of the fetus. Hospital stay for childbirth for mother and newborn may not be limited to less than 48 hours after vaginal birth or less than 96 hours after a cesarean section, unless the mother and attending provider request it.
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				Includes treatment in an outpatient department of a hospital and office visits, individual psychotherapy, group psychotherapy, psychological testing and medication management visits. Services may be received by a psychiatrist, psychologist, neuropsychologist, licensed clinical social worker (L.C.S.W.), mental health clinical nurse specialist, licensed marriage and family therapist (L.M.F.T.), licensed professional counselor (L.P.C) or any agency licensed by the state to give these services that must be covered by law.
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				Includes services in a hospital or any facility required to be covered by state law. Inpatient benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, convulsive therapy, detoxification, and rehabilitation.
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				Includes treatment in an outpatient department of a hospital and office visits, individual psychotherapy, group psychotherapy, psychological testing and medication management visits. Services may be received by a psychiatrist, psychologist, neuropsychologist, licensed clinical social worker (L.C.S.W.), mental health clinical nurse specialist, licensed marriage and family therapist (L.M.F.T.), licensed professional counselor (L.P.C) or any agency licensed by the state to give these services that must be covered by law.
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				Includes services in a hospital or any facility required to be covered by state law. Inpatient benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, convulsive therapy, detoxification, and rehabilitation.

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Generic Drugs	Yes	Covered	No				Covers prescription legend drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy; self-administered injectable drugs; self-injectable insulin and supplies and equipment used to administer insulin; self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Includes coverage for special food products or supplements when prescribed by a Doctor when medically necessary; Flu Shots (including administration). Inpatient or IV therapy drugs used in the treatment of cancer pain will not be denied on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.
Preferred Brand Drugs	Yes	Covered	No				Covers prescription legend drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy; self-administered injectable drugs; self-injectable insulin and supplies and equipment used to administer insulin; self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Includes coverage for special food products or supplements when prescribed by a Doctor when medically necessary; Flu Shots (including administration). Inpatient or IV therapy drugs used in the treatment of cancer pain will not be denied on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.
Non-Preferred Brand Drugs	Yes	Covered	No				Covers prescription legend drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy; self-administered injectable drugs; self-injectable insulin and supplies and equipment used to administer insulin; self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Includes coverage for special food products or supplements when prescribed by a Doctor when medically necessary; Flu Shots (including administration). Inpatient or IV therapy drugs used in the treatment of cancer pain will not be denied on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

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Specialty Drugs	Yes	Covered	No				Covers prescription legend drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy; self-administered injectable drugs; specialty drugs; self-injectable insulin and supplies and equipment used to administer insulin; self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Includes coverage for special food products or supplements when prescribed by a Doctor when medically necessary; Flu Shots (including administration). Inpatient or IV therapy drugs used in the treatment of cancer pain will not be denied on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.
Outpatient Rehabilitation Services	Yes	Covered	No				Benefits are based on the setting in which covered services are received. See individual therapy limits.
Habilitation Services	Yes	Covered	No				Benefits that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, medical devices, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. See individual therapy limits.
Chiropractic Care	Yes	Covered	Yes	30	Visit(s) per Benefit Period		Includes therapy to treat problems of the bones, joints, joints of the spine, the nervous system, and the back, and osteopathic therapy which focuses on the joints and surrounding muscles, tendons and ligaments.

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Durable Medical Equipment	Yes	Covered	No				Includes Medical Devices, Orthotics, Medical and Surgical Supplies. Benefits include equipment and devices (e.g., crutches and customized equipment, Hospital beds and wheelchairs, oxygen concentrator, ventilator, and negative pressure, wound therapy devices). Coverage for ongoing rental of equipment may be limited to the cost of purchasing the equipment. Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair. Oxygen and equipment for its administration are also covered services. Benefits are also available for cochlear implants. Benefits are available for certain types of orthotics (braces, boots, and splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. Also, includes coverage for devices and supplies, such as APAP, CPAP, BPAP and oral devices for sleep treatment, subject to medical necessity.
Hearing Aids	No	Not Covered	No				This Exclusion does not apply to cochlear implants.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				Includes x-rays / regular imaging services; radiology (including mammograms), ultrasound or nuclear medicine; and advanced imaging, including CT scan, CTA scan, Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Magnetic Resonance Spectroscopy (MRS); Nuclear Cardiology; PET scans; PET/CT Fusion scans; QTC Bone Densitometry; Diagnostic CT Colonography; Single photon emission computed tomography (SPCECT) scans.

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Preventive Care/Screening/Immunization	Yes	Covered	No				Covers: (1) Services with an "A" or "B" rating from the United States Preventive Services Task Force; (2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (3) Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration (including infant hearing screening); (4) Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration; and (5) Counseling services related to nutrition, and to smoking and tobacco use cessation. Prescription drugs that help you stop smoking or reduce your dependence on tobacco products are also covered preventive services. Smoking cessation products and over the counter nicotine replacement products (limited to nicotine patches and gum) are covered when obtained with a prescription. Additionally, state law requires coverage for routine screening mammograms and routine prostate specific antigen testing and digital rectal exams.
Routine Foot Care	No	Not Covered	No				
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Benefit Period		Includes complete eye exam with dilation, as needed to check all aspects of vision, including the structure of the eyes and how well they work together.
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Benefit Period	Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.	Includes a choice of eyeglass lenses with factory scratch coating or contact lenses in one benefit period. Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in: Single vision; Bifocal; Trifocal (FT 25-28); and Progressive. Members choose from a limited frame selection. Coverage for contact lenses includes elective or non-elective contact lenses. Non-elective contact lenses are covered only for the following medical conditions: Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses; High Ametropia exceeding -12D or +9D in spherical equivalent; Anisometropia of 3D or more; when your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.
Dental Check-Up for Children	Yes	Covered	Yes	1	Treatment(s) per 6 Months		Includes coverage for D1110, D1120, D1203, D1204, D1206, and D1208.

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Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Benefit Period		Includes services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment. Limit does not apply when received as part of hospice benefit or early intervention benefit.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Benefit Period	Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts. Non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.	Includes treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, bathing, and therapy for tasks needed for the person's job. Also, includes the treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg by means of hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. Limit is combined for physical and occupational therapy habilitative and rehabilitative. Limit does not apply when received as part of hospice benefit or early intervention benefit.
Well Baby Visits and Care	Yes	Covered	No				Includes immunizations for children recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; Preventive care and screenings for infants as listed in the guidelines supported by the Health Resources and Services Administration (including infant hearing screening).
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				Includes benefits for tests or procedures to find or check a condition when specific symptoms exist, as well as benefits for interpretation of diagnostic tests such as imaging, and cardiology. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services: x-rays / regular imaging services; radiology (including mammograms), ultrasound or nuclear medicine.
Basic Dental Care - Child	Yes	Covered	No				Benefit limitations may apply to individual services.
Orthodontia - Child	Yes	Covered	Yes	1	Treatment(s) per Lifetime		Limit applies to one comprehensive orthodontic treatment of the adolescent dentition.
Major Dental Care - Child	Yes	Covered	No				Benefit limitations may apply to individual services.
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				

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Abortion for Which Public Funding is Prohibited	No	Covered	No				Pursuant to Virginia law no QHP sold or offered on an exchange shall provide coverage for abortions, provided that this limitation shall not apply to an abortion performed (i) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life endangering physical condition relating to the pregnancy, or (ii) when the pregnancy is the result of rape or incest.
Transplant	Yes	Covered	No				Includes coverage for medically necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes medically necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies. When a human organ transplant is provided from a living donor to a covered member, both the recipient and the donor may receive benefits.
Accidental Dental	Yes	Covered	No			An injury that results from chewing or biting is not considered an accidental injury and is not covered.	Includes dental work, to include oral / surgical correction needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a covered service.
Dialysis	Yes	Covered	No				Includes services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Dialysis treatments can be rendered in an outpatient dialysis Facility, doctor's office, or home dialysis and training for the covered person and the person who will help with home self-dialysis.
Allergy Testing	Yes	Covered	No				Includes benefits for medically necessary allergy testing and treatment, including allergy serum and allergy shots.
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				Includes treatment (tele therapy, brachytherapy and intraoperative radiation, photon or high-energy particle sources), materials and supplies needed, administration, and treatment planning.
Diabetes Education	Yes	Covered	No				Includes education for diabetes care for all diabetics, including outpatient self-management training and education performed in-person; medical nutrition therapy, when provided by a certified, licensed, or registered health care professional. Diabetic education may be received from pharmacies that are authorized to perform this service.

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Prosthetic Devices	Yes	Covered	No			Prosthetics, including wigs and scalp hair prosthetics, for sports or cosmetic purposes.	Includes benefits for prosthetics and components when they are medically necessary for activities of daily living. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot or eye. Coverage is also included for the repair, fitting, adjustments and replacement of a prosthetic device. In additional, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device. Covered services may include: 1) Artificial limbs and components (the materials and equipment needed to ensure the comfort and functioning of the prosthetic device); 2) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act. 3) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care. 4) Restoration prosthesis (composite facial prosthesis) 5) Wigs needed after cancer treatment (limited to one wig per benefit period).
Infusion Therapy	Yes	Covered	No				Includes nursing, durable medical equipment and drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Also covers prescription drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility.
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No			The medical benchmark benefits exclude fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).	Includes services to treat temporomandibular and craniomandibular disorders, such as removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Dental benchmark plan covers occlusal orthotic devices for temporomandibular pain, dysfunction or associated musculature.
Nutritional Counseling	Yes	Covered	No				

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Reconstructive Surgery	Yes	Covered	No				Includes reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Also includes surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a covered service. Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours.

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
Analgesics	Nonsteroidal Anti-inflammatory Drugs	21
Analgesics	Opioid Analgesics, Long-acting	14
Analgesics	Opioid Analgesics, Short-acting	16
Anesthetics	Local Anesthetics	3
Anti-Addiction/ Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	4
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Dependence Treatments	3
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Reversal Agents	1
Anti-Addiction/ Substance Abuse Treatment Agents	Smoking Cessation Agents	3
Antibacterials	Aminoglycosides	6
Antibacterials	Antibacterials, Other	18
Antibacterials	Beta-lactam, Cephalosporins	10
Antibacterials	Beta-lactam, Other	2
Antibacterials	Beta-lactam, Penicillins	5
Antibacterials	Macrolides	5
Antibacterials	Quinolones	10
Antibacterials	Sulfonamides	5
Antibacterials	Tetracyclines	4
Anticonvulsants	Anticonvulsants, Other	5
Anticonvulsants	Calcium Channel Modifying Agents	4
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Augmenting Agents	6
Anticonvulsants	Glutamate Reducing Agents	3
Anticonvulsants	Sodium Channel Agents	8
Antidementia Agents	Antidementia Agents, Other	1
Antidementia Agents	Cholinesterase Inhibitors	3
Antidementia Agents	N-methyl-D-aspartate (NMDA) Receptor Antagonist	1
Antidepressants	Antidepressants, Other	8
Antidepressants	Monoamine Oxidase Inhibitors	4
Antidepressants	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	13
Antidepressants	Tricyclics	9
Antiemetics	Antiemetics, Other	10
Antiemetics	Emetogenic Therapy Adjuncts	7
Antifungals	No USP Class	24
Antigout Agents	No USP Class	6
Anti-inflammatory Agents	Glucocorticoids	27
Anti-inflammatory Agents	Nonsteroidal Anti-inflammatory Drugs	20
Antimigraine Agents	Ergot Alkaloids	2

CATEGORY	CLASS	SUBMISSION COUNT
Antimigraine Agents	Prophylactic	3
Antimigraine Agents	Serotonin (5-HT) 1b/1d Receptor Agonists	7
Antimyasthenic Agents	Parasympathomimetics	3
Antimycobacterials	Antimycobacterials, Other	2
Antimycobacterials	Antituberculars	11
Antineoplastics	Alkylating Agents	4
Antineoplastics	Antiandrogens	4
Antineoplastics	Antiangiogenic Agents	3
Antineoplastics	Antiestrogens/Modifiers	3
Antineoplastics	Antimetabolites	5
Antineoplastics	Antineoplastics, Other	5
Antineoplastics	Aromatase Inhibitors, 3rd Generation	3
Antineoplastics	Enzyme Inhibitors	7
Antineoplastics	Molecular Target Inhibitors	18
Antineoplastics	Monoclonal Antibodies	1
Antineoplastics	Retinoids	3
Antiparasitics	Anthelmintics	3
Antiparasitics	Antiprotozoals	11
Antiparasitics	Pediculicides/Scabicides	6
Antiparkinson Agents	Anticholinergics	3
Antiparkinson Agents	Antiparkinson Agents, Other	3
Antiparkinson Agents	Dopamine Agonists	4
Antiparkinson Agents	Dopamine Precursors/ L-Amino Acid Decarboxylase Inhibitors	2
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	2
Antipsychotics	1st Generation/Typical	10
Antipsychotics	2nd Generation/Atypical	9
Antipsychotics	Treatment-Resistant	1
Antispasticity Agents	No USP Class	4
Antivirals	Anti-cytomegalovirus (CMV) Agents	2
Antivirals	Anti-hepatitis B (HBV) Agents	7
Antivirals	Anti-hepatitis C (HCV) Agents	10
Antivirals	Antiherpetic Agents	5
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	4
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	5
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	14
Antivirals	Anti-HIV Agents, Other	4
Antivirals	Anti-HIV Agents, Protease Inhibitors	9
Antivirals	Anti-influenza Agents	4

CATEGORY	CLASS	SUBMISSION COUNT
Anxiolytics	Anxiolytics, Other	4
Anxiolytics	Benzodiazepines	0
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	5
Bipolar Agents	Bipolar Agents, Other	7
Bipolar Agents	Mood Stabilizers	5
Blood Glucose Regulators	Antidiabetic Agents	28
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	10
Blood Products/Modifiers/ Volume Expanders	Anticoagulants	8
Blood Products/Modifiers/ Volume Expanders	Blood Formation Modifiers	6
Blood Products/Modifiers/ Volume Expanders	Coagulants	0
Blood Products/Modifiers/ Volume Expanders	Platelet Modifying Agents	9
Cardiovascular Agents	Alpha-adrenergic Agonists	4
Cardiovascular Agents	Alpha-adrenergic Blocking Agents	4
Cardiovascular Agents	Angiotensin II Receptor Antagonists	8
Cardiovascular Agents	Angiotensin-converting Enzyme (ACE) Inhibitors	10
Cardiovascular Agents	Antiarrhythmics	10
Cardiovascular Agents	Beta-adrenergic Blocking Agents	13
Cardiovascular Agents	Calcium Channel Blocking Agents	9
Cardiovascular Agents	Cardiovascular Agents, Other	6
Cardiovascular Agents	Diuretics, Carbonic Anhydrase Inhibitors	2
Cardiovascular Agents	Diuretics, Loop	4
Cardiovascular Agents	Diuretics, Potassium-sparing	4
Cardiovascular Agents	Diuretics, Thiazide	6
Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2
Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	7
Cardiovascular Agents	Dyslipidemics, Other	8
Cardiovascular Agents	Vasodilators, Direct-acting Arterial	4
Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	3
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	4
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	4
Central Nervous System Agents	Central Nervous System, Other	10
Central Nervous System Agents	Fibromyalgia Agents	3
Central Nervous System Agents	Multiple Sclerosis Agents	8
Dental and Oral Agents	No USP Class	8
Dermatological Agents	No USP Class	93
Enzyme Replacement/ Modifiers	No USP Class	8
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	4

CATEGORY	CLASS	SUBMISSION COUNT
Gastrointestinal Agents	Gastrointestinal Agents, Other	10
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	4
Gastrointestinal Agents	Irritable Bowel Syndrome Agents	3
Gastrointestinal Agents	Laxatives	4
Gastrointestinal Agents	Protectants	2
Gastrointestinal Agents	Proton Pump Inhibitors	6
Genitourinary Agents	Antispasmodics, Urinary	7
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	9
Genitourinary Agents	Genitourinary Agents, Other	8
Genitourinary Agents	Phosphate Binders	4
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	31
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)	No USP Class	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Anabolic Steroids	2
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Androgens	4
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	19
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progesterone Agonists/Antagonists	0
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	18
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	3
Hormonal Agents, Stimulant/Replacement/ Modifying (Pituitary)	No USP Class	6
Hormonal Agents, Stimulant/Replacement/ Modifying (Thyroid)	No USP Class	4
Hormonal Agents, Suppressant (Adrenal)	No USP Class	2
Hormonal Agents, Suppressant (Parathyroid)	No USP Class	3
Hormonal Agents, Suppressant (Pituitary)	No USP Class	8
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	3
Immunological Agents	Angioedema (HAE) Agents	1
Immunological Agents	Immune Suppressants	18
Immunological Agents	Immunizing Agents, Passive	1
Immunological Agents	Immunomodulators	19
Inflammatory Bowel Disease Agents	Aminosalicylates	3
Inflammatory Bowel Disease Agents	Glucocorticoids	5
Inflammatory Bowel Disease Agents	Sulfonamides	1
Metabolic Bone Disease Agents	No USP Class	15
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Analogs	3
Ophthalmic Agents	Ophthalmic Agents, Other	21
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	9
Ophthalmic Agents	Ophthalmic Antiglaucoma Agents	19
Ophthalmic Agents	Ophthalmic Anti-inflammatories	11
Otic Agents	No USP Class	8

CATEGORY	CLASS	SUBMISSION COUNT
Respiratory Tract/ Pulmonary Agents	Antihistamines	12
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	8
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	3
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	4
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	13
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	3
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	6
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	8
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	3
Skeletal Muscle Relaxants	No USP Class	6
Sleep Disorder Agents	GABA Receptor Modulators	3
Sleep Disorder Agents	Sleep Disorders, Other	6
Therapeutic Nutrients/ Minerals/ Electrolytes	Electrolyte/Mineral Modifiers	7
Therapeutic Nutrients/ Minerals/ Electrolytes	Electrolyte/Mineral Replacement	8
Therapeutic Nutrients/ Minerals/ Electrolytes	Vitamins	0