TENNESSEE EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	BlueCross BlueShield of Tennessee
Product Name	PPO
Plan Name	BCBST PPO
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

BENEFITS AND LIMITS

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Primary Care Visit to Treat an Injury or Illness	Yes	PCP-type office visit	Covered	No				a. Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings. b. Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain. c. Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace. d. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit. e. Dental procedures not related to medical emergencies.	Includes diagnosis/treatment of illness/injury; injections/ medications administered in office except specialty drugs; second surgical opinion; well child care; preventive/well care services.	No
Specialist Visit	Yes	Specialist office visit	Covered	No				a. Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings. b. Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain. c. Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace. d. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit. e. Dental procedures not related to medical emergencies.	Includes diagnosis/treatment of illness/injury; injections/ medications administered in office except specialty drugs; second surgical opinion; well child care; preventive/well care services.	No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Office visit with Physician Assistant or Nurse Practitioner	Covered	No				a. Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings. b. Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain. c. Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace. d. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit. e. Dental procedures not related to medical emergencies.	Includes diagnosis/treatment of illness/injury; injections/ medications administered in office except specialty drugs; second surgical opinion; well child care; preventive/well care services.	No

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Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Services	Covered	No				a. Rehabilitative therapies in excess of the terms of the Therapeutic/Rehabilitative benefit. b. Services that could be provided in a less intensive setting.	Covers Facility portion of: a. Outpatient diagnostics (such as x-rays and laboratory services); b. Outpatient treatments (such as medications and injections); c. Outpatient Surgery and supplies; d. Observation stays less than 24 hours.	No
Outpatient Surgery Physician/Surgical Services	Yes	Outpatient Physician/Surgical Services	Covered	No				a. Rehabilitative therapies in excess of the terms of the Therapeutic/Rehabilitative benefit. b. Services that could be provided in a less intensive setting.	Covers Physician/Practitioner portion of: a. Outpatient diagnostics (such as x-rays and laboratory services); b. Outpatient treatments (such as medications and injections); c. Outpatient Surgery and supplies; d. Observation stays less than 24 hours.	No
Hospice Services	Yes	Hospice Services	Covered	No				a. Inpatient hospice services, unless approved by Case Management. b. Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.	Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less. Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.	No
Non-Emergency Care When Traveling Outside the U.S.		Non-Emergency Care When Traveling Outside the U.S.	Covered	No				a. Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings. b. Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain. c. Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace. d. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit. e. Dental procedures not related to medical emergencies.	Includes diagnosis/treatment of illness/injury; injections/ medications administered in office except specialty drugs; second surgical opinion; well child care; preventive/well care services.	No
Routine Dental Services (Adult)			Not Covered							

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Infertility Treatment		Family Planning and Reproductive Services	Covered	No				a. Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments. b. Services or supplies for the reversals of sterilizations. c. Induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother; (2) the pregnancy is a result of rape or incest; or (3) the fetus is not viable; (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.	Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility. a. Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing. b. Sterilization procedures. c. Services or supplies for the evaluation of infertility. d. Medically Necessary and Appropriate termination of a pregnancy. e. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.	No
Long-Term/ Custodial Nursing Home Care			Not Covered							
Private-Duty Nursing			Not Covered							
Routine Eye Exam (Adult)			Not Covered							
Urgent Care Centers or Facilities	Yes	Urgent Care Centers or Facilities	Covered	No				a. Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings. b. Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain. c. Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace. d. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit. e. Dental procedures not related to medical emergencies.	Covered under the physician's office visit benefit. Includes diagnosis/ treatment of illness/injury; injections/medications administered in office except specialty drugs; second surgical opinion; well child care; preventive/well care services.	No

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Home Health Care Services	Yes	Home Health Care Services	Covered	Yes	60	Visits per year		a. Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) Maintenance Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (9) convenience items.	Medically Necessary and Appropriate services and supplies provided in Your home by a Practitioner who is primarily engaged in providing home health care services. Physical, speech or occupational therapy provided in the home applies to the Therapy Services visit limits: a. Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse; b. Home infusion therapy; c. Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/ Rehabilitative benefit.); d. Medical social services; e. Dietary guidance.	No
Emergency Room Services	Yes	Hospital Emergency Care Services	Covered	No				a. Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency. b. Services received for inpatient care or transfer to another facility once Your medical condition has stabilized.	Medically Necessary and Appropriate health care services and supplies furnished in a Hospital emergency department that are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol: a. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition. b. Practitioner services.	No
Emergency Transportation/ Ambulance	Yes	Emergency Land or Air Transportation	Covered	No				a. Transportation for Your convenience. b. Transportation that is not essential to reduce the probability of harm to You. c. Services when You are not transported to a hospital.	Medically Necessary and Appropriate land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to You. Medically Necessary and Appropriate land or air transportation from the scene of an accident or Emergency to the nearest appropriate hospital.	No

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Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No				a. Inpatient stays primarily for therapy (such as physical or occupational therapy). b. Services that could be provided in a less intensive setting. c. Private room when not Authorized by the Plan and room and board charges are in excess of semi-private room. d. Blood or plasma that is provided at no charge to the patient.	Medically Necessary and Appropriate services and supplies in a Hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of Physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility. a. Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room); general nursing care; medications, injections, diagnostic services and special care units; b. Attending Practitioner's services for professional care; c. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the hospital or physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.	No
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No				a. Inpatient stays primarily for therapy (such as physical or occupational therapy). b. Services that could be provided in a less intensive setting. c. Private room when not Authorized by the Plan and room and board charges are in excess of semi-private room. d. Blood or plasma that is provided at no charge to the patient.	Medically Necessary and Appropriate services and supplies in a Hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of Physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility. a. Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room); general nursing care; medications, injections, diagnostic services and special care units; b. Attending Practitioner's services for professional care; c. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the hospital or physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.	No
Bariatric Surgery			Not Covered							
Cosmetic Surgery			Not Covered							

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Skilled Nursing Facility	Yes	Skilled Nursing/ Rehabilitative Facility Services	Covered	Yes	60	Days combined per year		a. Custodial, domiciliary or private duty nursing services. b. Skilled Nursing services not received in a Medicare certified skilled nursing facility. c. Services for cognitive rehabilitation.	Medically Necessary and Appropriate Inpatient care provided to Members requiring medical, rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a hospital setting, or custodial or functional care rendered in a nursing home. a. Room and board in a semi-private room, general nursing care, medications, diagnostics and special care units; b. The attending Practitioner's services for professional care.	No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No					Maternity and delivery services (including routine nursery care and Complications of Pregnancy).	No
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Services for Maternity Care	Covered	No					Maternity and delivery services (including routine nursery care and Complications of Pregnancy).	No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health and Substance Outpatient Services	Covered	Yes	25	Visits per year combined for mental/behavioral health and substance abuse		a. Pastoral Counseling; b. Marriage and family counseling without a behavioral health diagnosis; c. Vocational and educational training and/or services; d. Custodial or domiciliary care; e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs; f. Sleep disorders; g. Services related to mental retardation; h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained; i. Court ordered examinations and treatment, unless Medically Necessary; j. Pain management; k. Hypnosis or regressive hypnotic techniques; l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.	Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. a. Outpatient services for care and treatment of mental health disorders and substance abuse disorders. b. The Plan may substitute other levels of care for inpatient days.	No
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health and Substance Inpatient Services	Covered	Yes	20	Days per year combined for mental/behavioral health and substance abuse		a. Pastoral Counseling; b. Marriage and family counseling without a behavioral health diagnosis; c. Vocational and educational training and/or services; d. Custodial or domiciliary care; e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs; f. Sleep disorders. g. Services related to mental retardation; h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained; i. Court ordered examinations and treatment, unless Medically Necessary; j. Pain management; k. Hypnosis or regressive hypnotic techniques; l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.	Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. a. Inpatient services for care and treatment of mental health disorders and substance abuse disorders. b. The Plan may substitute other levels of care for inpatient days.	No

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Substance Abuse Disorder Outpatient Services	Yes	Mental/Behavioral Health and Substance Outpatient Services	Covered	Yes	25	Visits per year combined for mental/behavioral health and substance abuse		a. Pastoral Counseling; b. Marriage and family counseling without a behavioral health diagnosis; c. Vocational and educational training and/or services; d. Custodial or domiciliary care; e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs; f. Sleep disorders; g. Services related to mental retardation; h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained; i. Court ordered examinations and treatment, unless Medically Necessary; j. Pain management; k. Hypnosis or regressive hypnotic techniques; l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.	Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. a. Outpatient services for care and treatment of mental health disorders and substance abuse disorders. b. The Plan may substitute other levels of care for inpatient days.	No
Substance Abuse Disorder Inpatient Services	Yes	Mental/Behavioral Health and Substance Inpatient Services	Covered	Yes	20	Days per year combined for mental/behavioral health and substance abuse		a. Pastoral Counseling; b. Marriage and family counseling without a behavioral health diagnosis; c. Vocational and educational training and/or services; d. Custodial or domiciliary care; e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs; f. Sleep disorders; g. Services related to mental retardation; h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained; i. Court ordered examinations and treatment, unless Medically Necessary; j. Pain management; k. Hypnosis or regressive hypnotic techniques; l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.	Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. a. Inpatient services for care and treatment of mental health disorders and substance abuse disorders. b. The Plan may substitute other levels of care for inpatient days.	No
Generic Drugs	Yes	Generic Prescription Drugs	Covered	No						No
Preferred Brand Drugs	Yes	Preferred Brand Prescription Drugs	Covered	No						No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Prescription Drugs	Covered	No						No
Specialty Drugs	Yes	Self-Administered Specialty Prescription Drugs	Covered	No						Yes

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Outpatient Rehabilitation Services	Yes	Outpatient Physical Therapy Services	Covered	Yes	20	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner; b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services; (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate; c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	Yes

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Habilitation Services	Yes	Habilitation Physical Therapy Services	Covered	Yes	20	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner; b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	Yes

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Chiropractic Care	Yes	Outpatient Chiropractic Care	Covered	Yes	20	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner. b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	No

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Durable Medical Equipment	Yes	Durable Medical Equipment	Covered	No				a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment; b. Unnecessary repair, adjustment or replacement or duplicates of any such equipment; c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment; d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology; e. Items that require or are dependent on alteration of home, workplace or transportation vehicle; f. Motorized scooters, exercise equipment, hot tubs, pool, saunas; g. "Deluxe" or "enhanced" equipment. The most basic equipment that will provide the needed medical care will determine the benefit; h. Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind; i. Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management.	Medically Necessary and Appropriate medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to You; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for Your convenience. a. Rental of durable medical equipment. Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase; b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment; c. Supplies and accessories necessary for the effective functioning of Covered durable medical equipment; d. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is Covered only for pumps older than 48 months and only if the pump cannot be repaired.	No
Hearing Aids	Yes	Hearing Aids	Covered	Yes	1000	Dollars per year every 3 years		Hearing aids for Members age 18 or older.	Hearing aids for Members under age 18	No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Test (X-ray and lab work)	Covered	No				a. Diagnostic services that are not Medically Necessary and Appropriate. b. Diagnostic services not ordered by a Practitioner.	Medically Necessary and Appropriate diagnostic radiology services and laboratory tests. a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. b. Diagnostic laboratory services ordered by a Practitioner.	No
Imaging (CT/PET Scans, MRIs)	Yes	Advanced Radiological Imaging (CT/PET Scans, MRIs)	Covered	No				a. Diagnostic services that are not Medically Necessary and Appropriate. b. Diagnostic services not ordered by a Practitioner.	Medically Necessary and Appropriate diagnostic radiology services and laboratory tests. a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. b. Diagnostic laboratory services ordered by a Practitioner.	No

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Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screening/ Immunization	Covered	Yes	1	Well Care visit per year except for Well child care under age 6.			Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually. d. Well Child Care for children through age 5, including appropriate immunizations, screenings and diagnostics. Once the member reaches age 6, well care services are provided as described below. e. Preventive/Well Care Services: (i) Annual preventive health exam for adults and children age six and older, including screenings, and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam. (ii) Preventive health exam for children through age 5, including screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam ("Well Child Care"); (iii) Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC); (iv) Annual Well Woman Exam, including cervical cancer screening, screening mammography at age 40 and older, and other screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF); (v) Colorectal cancer screening (age 50-75); (vi) Prostate cancer screening for men age 50 and older; (vii) Screening and counseling in the primary care setting for alcohol misuse and tobacco use; (viii) Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.	No
Routine Foot Care		Routine Foot Care	Covered	No				Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain.	Covered only for members with diabetes.	No
Acupuncture			Not Covered							
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam	Covered	Yes	1	Visit per year				No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of glasses (lenses and frames) per year				No

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Dental Check-Up for Children	Yes	Dental Exams	Covered	Yes	1	Visit every 6 months			Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	Yes	20	Visits per year				No
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	Yes	40	Visits per year				No
Well Baby Visits and Care	Yes	Well Baby Visits and Care	Covered	No						No
Laboratory Outpatient and Professional Services	Yes	Laboratory Outpatient and Professional Services	Covered	No						No
X-rays and Diagnostic Imaging	Yes	X-rays and Diagnostic Imaging	Covered	No						No
Basic Dental Care - Child	Yes	Basic Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Orthodontia - Child	Yes	Orthodontia - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Major Dental Care - Child	Yes	Major Dental Care - Child	Covered	No					Limitations, including dollar limits, may apply, see EHB benchmark plan documents.	No
Basic Dental Care - Adult			Not Covered							
Orthodontia - Adult			Not Covered							
Major Dental Care – Adult			Not Covered							
Abortion for Which Public Funding is Prohibited			Not Covered							

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Transplant	Yes	Organ Transplants	Covered	No				The following limitations and/or conditions apply to services, supplies or Charges: a. You or Your Practitioner must notify Transplant Case Management prior to Your receiving any Transplant Service, including pre-transplant evaluation. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all; b. Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation; c. Failure to notify Us of proposed Transplant Services, or to coordinate all transplant related services with Us, will result in the reduction or exclusion of payment for those services. The following services, supplies and Charges are not Covered under this section: a. Any service specifically excluded under Attachment B, Other Exclusions, except as otherwise provided in this section; b. Services or supplies not specified as Covered Services under this section; c. Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control; d. Non-Covered Services; e. Services that would be covered by any private or public research fund, regardless of whether You applied for or received amounts from such fund; f. Any non-human, artificial or mechanical organ; g. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ; h. Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provisions; i. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled within 3 months of harvest; j. Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.	Medically Necessary and Appropriate services and supplies provided to You, when You are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures that, in Our sole discretion, are not experimental or Investigational and that are Medically Necessary and Medically Appropriate. a. Medically Necessary and Appropriate services and supplies; b. Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant; c. Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for You and a companion. A companion must be Your spouse, family member, Your guardian or other person approved by Transplant Case Management. In order to be reimbursed, travel must be approved by Transplant Case Management. (i) Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the In-Transplant Network; (ii) Meals and lodging expenses are Covered, limited to $150 daily; (iii) The aggregate limit for travel expenses is $10,000 per Covered Procedure; (iv) Travel Expenses are Covered only if You go to an In-Transplant Network Institution. d. Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the Transplant Service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; (4) transportation of the organ to the site of transplant; and (5) donor follow-up care. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.	No
Accidental Dental	Yes	Accidental Dental	Covered	No						No
Dialysis	Yes	Dialysis	Covered	No						No
Allergy Testing	Yes	Allergy Testing	Covered	No						No
Chemotherapy	Yes	Chemotherapy	Covered	No						No

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Radiation	Yes	Radiation	Covered	No						No
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices	Yes	Prosthetics and Orthotics	Covered	No				a. Hearing aids for members over the age of 18; b. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants; c. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology; d. The replacements of contacts after the initial pair have been provided following cataract Surgery; e. Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as a part of a leg brace.	Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) Surgery. a. The initial purchase of surgically implanted prosthetic or orthotic devices; b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment; c. Splints and braces that are custom made or molded, and are incidental to a Practitioner's services or on a Practitioner's order; d. The replacement of Covered items required as a result of normal wear and tear, defects or obsolescence and aging; e. The initial purchase of artificial limbs or eyes; f. The first set of eyeglasses or contact lens required to adjust for vision changes due to cataract surgery and obtained within 6 months following the Surgery.	No
Infusion Therapy	Yes	Infusion Therapy	Covered	No						No
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No				a. Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth. b. Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.	Medically Necessary and Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD). a. Diagnosis and management of TMJ or TMD; b. Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon; c. Non-surgical TMJ includes: (1) history and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) Oral Appliances to stabilize jaw joint.	No
Nutritional Counseling	Yes	Nutritional Counseling	Covered	No						No
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No				a. Services, supplies or prosthetics primarily to improve appearance; b. Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service; c. Surgeries and related services to change gender (transsexual Surgery).	Medically Necessary and Appropriate Surgical Procedures intended to restore normal form or function. a. Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state; b. Reconstructive breast Surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.	No
Clinical Trials	Yes	Clinical Trials	Covered	No						No

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Diabetes Care Management	Yes	Diabetes Care Management	Covered	No				a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary; b. Supplies not required by state statute.	Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. If prescription drugs are Covered under a supplemental Rider, items a. through j. will be Covered under that Rider. a. Blood glucose monitors, including monitors designed for the legally blind; b. Test strips for blood glucose monitors; c. Visual reading and urine test strips; d. Insulin; e. Injection aids; f. Syringes; g. Lancets; h. Oral hypoglycemic agents; i. Glucagon emergency kits; j. Injectable incretin mimetics (e.g., Exenatide/Byetta) when used in conjunction with selected Prescription Drugs for the treatment of diabetes; k. Insulin pumps, infusion devices, and appurtenances; l. Podiatric appliances for prevention of complications associated with diabetes.	No
Inherited Metabolic Disorder - PKU	Yes	Inherited Metabolic Disorder - PKU	Covered	No						No
Off Label Prescription Drugs	Yes	Off Label Prescription Drugs	Covered	No						No
Dental Anesthesia	Yes	Dental Anesthesia	Covered	No						No
Congenital Anomaly, including Cleft Lip/Palate	Yes	Congenital Anomaly, including Cleft Lip/Palate	Covered	No						No

OTHER BENEFITS

Benefit Information			General Information							
A Benefit	B EHB	C Benefit Description (may be the same as the Benefit name)	D Is the Benefit Covered?	E Quantitative Limit on Service?	F Limit Quantity	G Limit Unit and/or Description	H Minimum Stay	I Exclusions	J Explanations	K Additional Limitations or Restrictions?
Specialty Drugs	Yes	Provider Administered Specialty Drugs	Covered	No				a. Self-administered Specialty Drugs as identified on the Plan's Specialty Drug list, except as may be Covered by a supplemental Rider; b. FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.	Medically Necessary and Appropriate Specialty Drugs for the treatment of disease administered by a Practitioner or home health care agency and listed as a Provider-administered drug on the Plan's Specialty Drug list.	No
Outpatient Rehabilitation Services	Yes	Outpatient Occupational Therapy Services	Covered	Yes	20	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable). f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner. b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	Yes

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Outpatient Rehabilitation Services	Yes	Outpatient Speech Therapy Services	Covered	Yes	20	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner. b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	Yes

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Outpatient Rehabilitation Services	Yes	Outpatient Cardiac Rehabilitation Services	Covered	Yes	36	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner. b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	Yes

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Outpatient Rehabilitation Services	Yes	Outpatient Pulmonary Rehabilitation Services	Covered	Yes	36	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner. b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	No

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Dental Services	Yes	Dental Services	Covered	No				a. Routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) tooth extraction, except as listed above; (8) periodontal Surgery; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar Surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth. b. Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints and occlusal appliances to treat malocclusion/ misalignment of teeth; c. Extraction of impacted teeth, including wisdom teeth. However, if both Your medical and dental plans are insured through BCBST under the same group number, this medical plan will pay secondary benefits for extraction of impacted teeth after Your BCBST dental plan has paid its benefits.	Medically Necessary and Appropriate services performed by a doctor of dental Surgery (DDS), a doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental related oral Surgery except as indicated below. a. Dental services and oral surgical care resulting from an accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services must be started within 3 months and completed within 12 months of the accident; b. For dental services not listed in subsection a. above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are Covered, only when one of the 5 conditions listed below is met. (1) Complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery; (2) Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications; (3) Mental illness or behavioral condition that precludes dental Surgery in the office; (4) Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or (5) Dental treatment or Surgery performed on a Member 8 years of age or younger, where such procedure cannot be safely provided in a dental office setting. c. Oral Appliances to treat obstructive sleep apnea, if Medically Necessary; d. Tooth extraction needed due to accidental injury of teeth caused by external trauma.	No
Vision	Yes	Vision	Covered	No				a. Routine vision services, including services, surgeries and supplies to detect or correct refractive errors of the eyes; b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses; c. Eye exercises and/or therapy; d. Visual training.	Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries that impair vision. a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye; b. The first set of eyeglasses or contact lens required to adjust for vision changes due to cataract Surgery and obtained within 6 months following the Surgery.	No
Medical Supplies	Yes	Medical Supplies	Covered	No				a. Supplies that can be obtained without a prescription (except for diabetic supplies). Examples include but are not limited to: (1) adhesive bandages; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.	Those Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury. a. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility or inpatient facility; b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner's prescription.	No

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Habilitation Services	Yes	Habilitation Speech Therapy Services	Covered	Yes	20	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner; b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; • Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	Yes

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Habilitation Services	Yes	Habilitation Occupational Therapy Services	Covered	Yes	20	Visits per year		a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care; b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state; c. Complementary and alternative therapeutic services; d. Modalities that do not require the attendance or supervision of a licensed therapist; e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable); f. Duplicate therapy.	a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner; b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate. c. Coverage is limited to: The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting; Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	9
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	1
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	1
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	5
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	10
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
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	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	20
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	9
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	1
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	2
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	7
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
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	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	7
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	20
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
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	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
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	5
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	3
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	3
DENTAL AND ORAL AGENTS	NO USP CLASS	7
DERMATOLOGICAL AGENTS	NO USP CLASS	31
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	7

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	5
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	6
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	6
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	11
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	5
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	11
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	15
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	0
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	7