



**Title:** Revised Benchmark Benefits Instructions

**Subtitle:** Instructions for using state-specific information to accurately reflect Individual Market and Small Group Market EHB and state-required benefits on the Plans and Benefits Template.

**Purpose:** This document provides issuers with instructions for correcting the Benefits Package Worksheet of the Plans and Benefits Template using the included state-specific worksheets (e.g., AK, HI, PA).

**Version:** 1

**Date:** Thursday, May 15, 2014



**2 Select the appropriate scenario based on the corrections identified in the state-specific spreadsheet**

Select the appropriate scenario below (A, B, or C) for each benefit indicated to have a correction to the data populated by the Add-In File in the state-specific spreadsheet.

Scenario A	The state-specific worksheet <b>DOES</b> identify a given benefit as an <i>EHB</i> and/or <i>State Required Benefit</i> and the benefit <b>DOES NOT</b> appear on the Plans and Benefits Template (" <i>Fields Changed</i> " = "Added Benefit"):	
	Cover	If you intend to cover the benefit, add the benefit using the "Add Benefit" button on the menu bar under the Plans and Benefits ribbon, select "Covered" in the " <i>Is this Benefit Covered?</i> " field, and select "Additional EHB" as the " <i>EHB Variance Reason.</i> "
	Do Not Cover	<p>If you do <u>not</u> intend to cover the benefit and instead want to substitute with actuarially equivalent coverage of another benefit in the same EHB category, add the benefit using the "Add Benefit" button on the menu bar under the Plans &amp; Benefits ribbon, select "Not Covered" in the "<i>Is this Benefit Covered?</i>" field, and select "Substituted" as the "<i>EHB Variance Reason.</i>" [For the "new" benefit that is taking the place of this one, select "Additional EHB Benefit" as the "<i>EHB Variance Reason.</i>"]</p> <p>If you do <u>not</u> intend to cover a pediatric dental benefit and there is a stand-alone dental plan available, add the pediatric dental benefit using the "Add Benefit" button on the menu bar, select "Not Covered," and select "Dental Only Plan Available" as the "<i>EHB Variance Reason.</i>"</p>
Scenario B	The state-specific spreadsheet <b>DOES</b> identify a given benefit as an <i>EHB</i> and/or <i>State Required Benefit</i> and the benefit <b>DOES</b> appear on the Plans & Benefits Template, but the " <i>Is this Benefit Covered?</i> " field is BLANK:	
	Cover	If you intend to cover the benefit, add "Covered" in the " <i>Is this Benefit Covered?</i> " field and select "Additional EHB Benefit" as the " <i>EHB Variance Reason.</i> "
	Do Not Cover	<p>If you do <u>not</u> intend to cover the benefit and instead intend to substitute with actuarially equivalent coverage of another benefit in the same EHB category, select "Not Covered" in the "<i>Is this Benefit Covered?</i>" field and select "Substituted" as the <i>EHB Variance Reason.</i> [For the "new" benefit that is taking the place of this one, select "Additional EHB Benefit" as the "<i>EHB Variance Reason.</i>"]</p> <p>If you do <u>not</u> intend to cover a pediatric dental benefit and there is a stand-alone dental plan available, select "Not Covered" and select "Dental Only Plan Available" as the "<i>EHB Variance Reason.</i>"</p>
Scenario C	The state-specific worksheet <b>DOES NOT</b> identify a given benefit as an <i>EHB</i> and/or <i>State Required Benefit</i> and the Plans & Benefits Template <b>DOES</b> populate the benefit as "Covered" in the <i>Is this Benefit Covered?</i> field:	
	Cover	If you intend to cover the benefit, leave "Covered" in the " <i>Is this Benefit Covered?</i> " field and select "Above EHB" as the " <i>EHB Variance Reason.</i> "
	Do Not Cover	If you do <u>not</u> intend to cover the benefit, change "Covered" to "Not Covered" in the " <i>Is this Benefit Covered?</i> " field and select "Above EHB" as the " <i>EHB Variance Reason.</i> "



Individual Market Add-In Changes		Benefit Information				General Information					
Fields Changed	Is this a correction to the data populated by the Add-In file on the state Benefit Package?	Benefits	EHB	State-Required Benefit	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Benefit Explanation
	No	Primary Care Visit to Treat an Injury or Illness	Yes		Covered						
	No	Specialist Visit	Yes	Yes	Covered						
	No	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered						
	No	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered						
State-Required Benefit	Yes	Outpatient Surgery Physician/Surgical Services	Yes	Yes	Covered						
Limit Quantity, Limit Unit, Benefit Explanation	Yes	Hospice Services	Yes		Covered	Yes	210	Visit(s) per Year			
	No	Non-Emergency Care When Traveling Outside the U.S.									
	No	Routine Dental Services (Adult)									
Benefit Explanation	Yes	Infertility Treatment	Yes	Yes	Covered						Excludes IVF, GIFT & ZIFT.
	No	Long-Term/Custodial Nursing Home Care									
	No	Private-Duty Nursing									
	No	Routine Eye Exam (Adult)									
	No	Urgent Care Centers or Facilities	Yes		Covered						
	No	Home Health Care Services	Yes	Yes	Covered	Yes	40	Visit(s) per Year			
	No	Emergency Room Services	Yes	Yes	Covered						
	No	Emergency Transportation/Ambulance	Yes	Yes	Covered						
	No	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Covered						
Benefit Explanation	Yes	Inpatient Physician and Surgical Services	Yes	Yes	Covered						
State-Required Benefit	Yes	Bariatric Surgery	Yes	Yes	Covered						
	No	Cosmetic Surgery									
	No	Skilled Nursing Facility	Yes		Covered	Yes	200	Days per Year			
State-Required Benefit	Yes	Prenatal and Postnatal Care	Yes	Yes	Covered						
	No	Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Covered						
State-Required Benefit, Limit Quantity, Limit Unit	Yes	Mental/Behavioral Health Outpatient Services	Yes	Yes	Covered						
State-Required Benefit, Limit Quantity, Limit Unit	Yes	Mental/Behavioral Health Inpatient Services	Yes	Yes	Covered						
State-Required Benefit, Limit Quantity, Limit Unit	Yes	Substance Abuse Disorder Outpatient Services	Yes	Yes	Covered						
Benefit Explanation	Yes	Substance Abuse Disorder Inpatient Services	Yes		Covered						
	No	Generic Drugs	Yes		Covered						
	No	Preferred Brand Drugs	Yes		Covered						
	No	Non-Preferred Brand Drugs	Yes		Covered						
	No	Specialty Drugs	Yes		Covered						
Benefit Explanation	Yes	Outpatient Rehabilitation Services	Yes		Covered						60 visits per condition per lifetime combined. Speech & physical therapy are only covered following a hospital stay or surgery.

Individual Market Add-In Changes		Benefit Information			General Information						
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Benefit Explanation	Yes	Habilitation Services	Yes		Covered						60 visits per condition per lifetime combined
	No	Chiropractic Care	Yes	Yes	Covered						
Limit Quantity, Limit Unit	Yes	Durable Medical Equipment	Yes		Covered						
Benefit Explanation	Yes	Hearing Aids	Yes		Covered						Single purchase once every three years
	No	Imaging (CT/PET Scans, MRIs)	Yes		Covered						
Benefit Explanation	Yes	Preventive Care/Screening/Immunization	Yes	Yes	Covered						
	No	Routine Foot Care									
	No	Acupuncture									
	No	Weight Loss Programs									
	No	Routine Eye Exam for Children	Yes		Covered						
	No	Eye Glasses for Children	Yes		Covered	Yes	1	Item(s) per Year			
	No	Dental Check-Up for Children	Yes		Covered	Yes	2	Visit(s) per Year			
EHB, Benefit Explanation	Yes	Rehabilitative Speech Therapy	Yes		Covered						60 outpatient visits per condition per lifetime combined. Speech therapy is only covered following a Hospital stay or surgery.
EHB, Benefit Explanation	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes		Covered						60 outpatient visits per condition per lifetime combined. Physical therapy is only covered following a Hospital stay or surgery.
EHB, State-Required Benefit	Yes	Well Baby Visits and Care	Yes	Yes	Covered						
State-Required Benefit	Yes	Laboratory Outpatient and Professional Services	Yes		Covered						
	No	X-rays and Diagnostic Imaging	Yes		Covered						
	No	Basic Dental Care – Child	Yes		Covered						
	No	Orthodontia – Child	Yes		Covered						
	No	Major Dental Care – Child	Yes		Covered						
	No	Basic Dental Care – Adult									
	No	Orthodontia – Adult									
	No	Major Dental Care – Adult									
EHB, Limit Quantity, Limit Unit	Yes	Abortion for Which Public Funding is Prohibited									
	No	Transplant	Yes		Covered						
State-Required Benefit	Yes	Accidental Dental	Yes	Yes	Covered						
	No	Dialysis	Yes		Covered						
	No	Allergy Testing	Yes		Covered						

Individual Market Add-In Changes		Benefit Information			General Information						
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	No	Chemotherapy	Yes		Covered						
EHB	Yes	Radiation	Yes		Covered						
State-Required Benefit	Yes	Diabetes Education	Yes	Yes	Covered						
	No	Prosthetic Devices	Yes		Covered						1 external prosthetic device per limb per lifetime (limit does not apply to internal devices)
EHB	Yes	Infusion Therapy	Yes		Covered						
EHB, Benefit Explanation	Yes	Treatment for Temporomandibular Joint Disorders	Yes		Covered						Covered when medical in nature
EHB, Benefit Explanation	Yes	Nutritional Counseling	Yes		Covered						Covered in accordance with USPSTF A & B recommendations.
State-Required Benefit	Yes	Reconstructive Surgery	Yes	Yes	Covered						
EHB	Yes	Diabetes Care Management	Yes	Yes	Covered						
EHB	Yes	Inherited Metabolic Disorder - PKU	Yes	Yes	Covered						
State-Required Benefit	Yes	Prescription Drugs Other									
EHB	Yes	Post-Mastectomy Care	Yes	Yes	Covered						
EHB, Limit Quantity, Limit Unit, Benefit Explanation	Yes	Autism Spectrum Disorders	Yes	Yes	Covered	Yes	680	Hours per Year			Coverage applicable to ABA treatment for autism spectrum disorders.
EHB	Yes	Breast Reconstructive Surgery	Yes	Yes	Covered						
EHB	Yes	Experimental or Investigational Services	Yes	Yes	Covered						
Added Benefit	Yes	Family Planning Services	Yes	Yes	Covered						

Small Group Market Add-In Changes		Benefit Information			General Information						
Fields Changed	Is this a correction to the data populated by the Add-In file on the state Benefit Package?	Benefits	EHB	State-Required Benefit	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Benefit Explanation
	No	Primary Care Visit to Treat an Injury or Illness	Yes		Covered						
	No	Specialist Visit	Yes	Yes	Covered						
	No	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered						
	No	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered						
State-Required Benefit	Yes	Outpatient Surgery Physician/Surgical Services	Yes	Yes	Covered						
Limit Quantity, Limit Unit, Benefit Explanation	Yes	Hospice Services	Yes		Covered	Yes	210	Visit(s) per Year			
	No	Non-Emergency Care When Traveling Outside the U.S.									
	No	Routine Dental Services (Adult)									
Benefit Explanation	Yes	Infertility Treatment	Yes	Yes	Covered						Excludes IVF, GIFT & ZIFT.
	No	Long-Term/Custodial Nursing Home Care									
	No	Private-Duty Nursing									
	No	Routine Eye Exam (Adult)									
	No	Urgent Care Centers or Facilities	Yes		Covered						
	No	Home Health Care Services	Yes	Yes	Covered	Yes	40	Visit(s) per Year			
	No	Emergency Room Services	Yes	Yes	Covered						
	No	Emergency Transportation/Ambulance	Yes	Yes	Covered						
	No	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Covered						
Benefit Explanation	Yes	Inpatient Physician and Surgical Services	Yes	Yes	Covered						
State-Required Benefit	Yes	Bariatric Surgery	Yes	Yes	Covered						
	No	Cosmetic Surgery									
	No	Skilled Nursing Facility	Yes		Covered	Yes	200	Days per Year			
State-Required Benefit	Yes	Prenatal and Postnatal Care	Yes	Yes	Covered						
	No	Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Covered						
State-Required Benefit, Limit Quantity, Limit Unit	Yes	Mental/Behavioral Health Outpatient Services	Yes	Yes	Covered						
Limit Quantity, Limit Unit	Yes	Mental/Behavioral Health Inpatient Services	Yes	Yes	Covered						
Limit Quantity, Limit Unit	Yes	Substance Abuse Disorder Outpatient Services	Yes	Yes	Covered						
Benefit Explanation	Yes	Substance Abuse Disorder Inpatient Services	Yes		Covered						
	No	Generic Drugs	Yes		Covered						
	No	Preferred Brand Drugs	Yes		Covered						
	No	Non-Preferred Brand Drugs	Yes		Covered						
	No	Specialty Drugs	Yes		Covered						
Benefit Explanation	Yes	Outpatient Rehabilitation Services	Yes		Covered						60 visits per condition per lifetime combined. Speech & physical therapy are only covered following a hospital stay or surgery.

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Limit Quantity, Limit Unit	Yes	Durable Medical Equipment	Yes		Covered						
Benefit Explanation	Yes	Hearing Aids	Yes		Covered						Single purchase once every three years
	No	Imaging (CT/PET Scans, MRIs)	Yes		Covered						
Benefit Explanation	Yes	Preventive Care/Screening/Immunization	Yes	Yes	Covered						
	No	Routine Foot Care									
	No	Acupuncture									
	No	Weight Loss Programs									
	No	Routine Eye Exam for Children	Yes		Covered						
	No	Eye Glasses for Children	Yes		Covered	Yes		1 Item(s) per Year			
	No	Dental Check-Up for Children	Yes		Covered	Yes		2 Visit(s) per Year			
EHB, Benefit Explanation	Yes	Rehabilitative Speech Therapy	Yes		Covered						60 outpatient visits per condition per lifetime combined. Speech therapy is only covered following a Hospital stay or surgery.
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EHB, State-Required Benefit	Yes	Well Baby Visits and Care	Yes	Yes	Covered						
State-Required Benefit	Yes	Laboratory Outpatient and Professional Services	Yes		Covered						
	No	X-rays and Diagnostic Imaging	Yes		Covered						
	No	Basic Dental Care – Child	Yes		Covered						
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EHB	Yes	Diabetes Care Management	Yes	Yes	Covered						
EHB	Yes	Inherited Metabolic Disorder - PKU	Yes	Yes	Covered						
State-Required Benefit	Yes	Prescription Drugs Other									
EHB	Yes	Post-Mastectomy Care	Yes	Yes	Covered						
EHB, Limit Quantity, Limit Unit, Benefit Explanation	Yes	Autism Spectrum Disorders	Yes	Yes	Covered	Yes	680	Hours per Year			Coverage applicable to ABA treatment for autism spectrum disorders.
EHB	Yes	Breast Reconstructive Surgery	Yes	Yes	Covered						
Added Benefit	Yes	Eating Disorder Treatment	Yes	Yes	Covered						
EHB	Yes	Experimental or Investigational Services	Yes	Yes	Covered						
Added Benefit	Yes	Family Planning Services	Yes	Yes	Covered						