



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 DOES identify a given benefit as an <i>EHB</i> and/or <i>State Required Benefit</i> and the benefit DOES NOT 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 & 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 DOES identify a given benefit as an <i>EHB</i> and/or <i>State Required Benefit</i> and the benefit DOES 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 DOES NOT identify a given benefit as an <i>EHB</i> and/or <i>State Required Benefit</i> and the Plans & Benefits Template DOES 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		Covered						
	No	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered						
	No	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered						
	No	Outpatient Surgery Physician/Surgical Services	Yes		Covered						
	No	Hospice Services	Yes		Covered	Yes	6	Months per Episode			
EHB	Yes	Non-Emergency Care When Traveling Outside the U.S.									
	No	Routine Dental Services (Adult)									
	No	Infertility Treatment									
	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		Covered	Yes	60	Visit(s) per Benefit Period			
	No	Emergency Room Services	Yes		Covered						
	No	Emergency Transportation/Ambulance	Yes		Covered						
	No	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Covered						
	No	Inpatient Physician and Surgical Services	Yes		Covered						
	No	Bariatric Surgery									
	No	Cosmetic Surgery									
	No	Skilled Nursing Facility	Yes		Covered	Yes	60	Days per Benefit Period			
	No	Prenatal and Postnatal Care	Yes		Covered						
	No	Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Covered						
	No	Mental/Behavioral Health Outpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Mental/Behavioral Health Inpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Substance Abuse Disorder Outpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Substance Abuse Disorder Inpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Generic Drugs	Yes		Covered						
	No	Preferred Brand Drugs	Yes		Covered						
	No	Non-Preferred Brand Drugs	Yes		Covered						
	No	Specialty Drugs	Yes		Covered						
	No	Outpatient Rehabilitation Services	Yes		Covered						

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	No	Habilitation Services									
Benefit Explanation	Yes	Chiropractic Care	Yes		Covered						Issuers that do not cover chiropractic services must offer an optional rider to provide for such coverage.
	No	Durable Medical Equipment	Yes		Covered						
	No	Hearing Aids									
	No	Imaging (CT/PET Scans, MRIs)	Yes		Covered						
	No	Preventive Care/Screening/Immunization	Yes	Yes	Covered						
EHB, Benefit Explanation	Yes	Routine Foot Care	Yes		Covered						Coverage only applicable to diabetes-related routine foot care
	No	Acupuncture									
	No	Weight Loss Programs									
	No	Routine Eye Exam for Children	Yes		Covered	Yes	1	Visit(s) per Year			
	No	Eye Glasses for Children	Yes		Covered	Yes	1	Item(s) per Year			
	No	Dental Check-Up for Children	Yes		Covered	Yes	1	Visit(s) per 6 Months			
	No	Rehabilitative Speech Therapy									
	No	Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes		Covered						30 Visits per benefit period for Physical Therapy
	No	Well Baby Visits and Care									
	No	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									
	No	Abortion for Which Public Funding is Prohibited									
	No	Transplant	Yes		Covered						
	No	Accidental Dental									
	No	Dialysis	Yes		Covered						
Benefit Explanation	Yes	Allergy Testing	Yes		Covered						Coverage applies to allergy testing and treatment.
	No	Chemotherapy	Yes		Covered						
	No	Radiation	Yes		Covered						

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EHB, State-Required Benefit	Yes	Diabetes Education	Yes	Yes	Covered						
	No	Prosthetic Devices	Yes		Covered	Yes	50000	Dollars per Benefit Period			
	No	Infusion Therapy	Yes		Covered						
	No	Treatment for Temporomandibular Joint Disorders									
	No	Nutritional Counseling									
State-Required Benefit, Benefit Explanation	Yes	Reconstructive Surgery	Yes		Covered						Must be to correct a functional disorder or result of injury
EHB	Yes	Diabetes Care Management	Yes	Yes	Covered						
EHB, Benefit Explanation	Yes	Off Label Prescription Drugs	Yes	Yes	Covered						Specific to drugs used for the treatment of cancer
EHB	Yes	Congenital Anomaly, including Cleft Lip/Palate	Yes	Yes	Covered						
EHB	Yes	Breast Reconstructive Surgery	Yes	Yes	Covered						

Small Group Market Add-In Changes		Benefit Information			General Information						
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	No	Primary Care Visit to Treat an Injury or Illness	Yes		Covered						
	No	Specialist Visit	Yes		Covered						
	No	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered						
	No	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered						
	No	Outpatient Surgery Physician/Surgical Services	Yes		Covered						
	No	Hospice Services	Yes		Covered	Yes	6	Months per Episode			
EHB	Yes	Non-Emergency Care When Traveling Outside the U.S.	Yes								
	No	Routine Dental Services (Adult)									
	No	Infertility Treatment									
	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		Covered	Yes	60	Visit(s) per Benefit Period			
	No	Emergency Room Services	Yes		Covered						
	No	Emergency Transportation/Ambulance	Yes		Covered						
	No	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Covered						
	No	Inpatient Physician and Surgical Services	Yes		Covered						
	No	Bariatric Surgery									
	No	Cosmetic Surgery									
	No	Skilled Nursing Facility	Yes		Covered	Yes	60	Days per Benefit Period			
	No	Prenatal and Postnatal Care	Yes		Covered						
	No	Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Covered						
	No	Mental/Behavioral Health Outpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Mental/Behavioral Health Inpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Substance Abuse Disorder Outpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Substance Abuse Disorder Inpatient Services	Yes		Covered						Quantitative limit units apply, see EHB benchmark.
	No	Generic Drugs	Yes		Covered						
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Benefit Explanation	Yes	Chiropractic Care	Yes		Covered						Issuers that do not cover chiropractic services must offer an optional rider to provide for such coverage.
	No	Durable Medical Equipment	Yes		Covered						
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	No	Imaging (CT/PET Scans, MRIs)	Yes		Covered						
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EHB, Benefit Explanation	Yes	Routine Foot Care	Yes		Covered						Coverage only applicable to diabetes-related routine foot care
	No	Acupuncture									
	No	Weight Loss Programs									
	No	Routine Eye Exam for Children	Yes		Covered	Yes	1	Visit(s) per Year			
	No	Eye Glasses for Children	Yes		Covered	Yes	1	Item(s) per Year			
	No	Dental Check-Up for Children	Yes		Covered	Yes	1	Visit(s) per 6 Months			
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	No	Basic Dental Care – Child	Yes		Covered						
	No	Orthodontia – Child	Yes		Covered						
	No	Major Dental Care – Child	Yes		Covered						
	No	Basic Dental Care – Adult									
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	No	Abortion for Which Public Funding is Prohibited									
	No	Transplant	Yes		Covered						
	No	Accidental Dental									
	No	Dialysis	Yes		Covered						
Benefit Explanation	Yes	Allergy Testing	Yes		Covered						Coverage applies to allergy testing and treatment.
	No	Chemotherapy	Yes		Covered						
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EHB, State-Required Benefit	Yes	Diabetes Education	Yes	Yes	Covered						
	No	Prosthetic Devices	Yes		Covered	Yes	50000	Dollars per Benefit Period			
	No	Infusion Therapy	Yes		Covered						
	No	Treatment for Temporomandibular Joint Disorders									
	No	Nutritional Counseling									
State-Required Benefit, Benefit Explanation	Yes	Reconstructive Surgery	Yes		Covered						Must be to correct a functional disorder or result of injury
EHB	Yes	Diabetes Care Management	Yes	Yes	Covered						
EHB, Benefit Explanation	Yes	Off Label Prescription Drugs	Yes	Yes	Covered						Specific to drugs used for the treatment of cancer
EHB	Yes	Congenital Anomaly, including Cleft Lip/Palate	Yes	Yes	Covered						
EHB	Yes	Breast Reconstructive Surgery	Yes	Yes	Covered						