NEW HAMPSHIRE EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from second largest small group product, Health Maintenance Organization
Issuer Name	Matthew Thornton Health Plan (Anthem BCBS)
Product Name	Matthew Thornton Blue
Plan Name	Matthew Thornton Blue Health Plan
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	Primary Care Visit to Treat an Injury or Illness	Covered	No						No
Specialist Visit	Yes	Specialist Visit	Covered	No						No
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Other Practitioner Office Visit	Covered	No						No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Outpatient Facility Services	Covered	No				Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
Outpatient Surgery Physician/Surgical Services	Yes	Physician Medical and Surgical Services in an Outpatient Facility	Covered	No				Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
Hospice Services	Yes	Hospice Services	Covered	No						No
Non-Emergency Care When Traveling Outside the U.S.			Not Covered							
Routine Dental Services (Adult)			Not Covered					No Benefits are available for preventive Dental Services. X-rays of the teeth are not covered. Orthodontia, TMJ appliances, splints or guards, braces, false teeth and biofeedback training are not covered. No Benefits are available for treatment or evaluation of a periodontal disorder, disease or abscess. Osseous and flap procedures, scaling, root planning, prophylaxis and periodontal evaluations are not covered. No Benefits are available for treatment of cavities or care of the gums. No Benefits are available for restorative Dental Services, even if the underlying dental condition affects other health factors. No Benefits are available for noncovered dental procedures. Covered.		
Infertility Treatment			Not Covered					No coverage for infertility treatments or ART procedures.	Benefits are available only to for diagnostic services to determine the cause of medically documented infertility.	

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?
Long-Term/Custodial Nursing Home Care			Not Covered					No Benefits are available for services, supplies or charges for Custodial Care. Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered.		
Private-Duty Nursing			Not Covered					Benefits are not provided for private duty nurses.		
Routine Eye Exam (Adult)		Routine Eye Exam	Covered	Yes	1	Visit every 2 years			Routine eye exam and refraction.	No
Urgent Care Centers or Facilities	Yes	Urgent Care Services in an Urgent Care Center or Facility	Covered	No						No
Home Health Care Services	Yes	Home Health Care Services	Covered	No				No Benefits are available for services, supplies or charges for Custodial Care.		No
Emergency Room Services	Yes	Emergency Room Services	Covered	No						No
Emergency Transportation/ Ambulance	Yes	Emergency Transportation/Ambulance	Covered	No						No
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Inpatient Hospital Services	Covered	No				No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Non covered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges. Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No

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?
Inpatient Physician and Surgical Services	Yes	Inpatient Physician and Surgical Services	Covered	No				No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Non covered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges. Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
Bariatric Surgery	Yes	Bariatric Surgery	Covered	No				Surgery to treat the condition of obesity itself or morbid obesity itself is not covered.	Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity.	No
Cosmetic Surgery			Not Covered					No benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical condition caused by or providing in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services.		
Skilled Nursing Facility	Yes	Skilled Nursing Facility	Covered	Yes	100	Days per year		No Benefits are available for services, supplies or charges for Custodial Care. No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Non covered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.		No
Prenatal and Postnatal Care	Yes	Prenatal and Postnatal Care	Covered	No				Costs associated with surrogate parenting or gestational carriers are not covered.		No

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?
Delivery and All Inpatient Services for Maternity Care	Yes	Delivery and All Inpatient Facility and Professional Services for Maternity Care	Covered	No			48	Costs associated with surrogate parenting or gestational carriers are not covered.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered. 48 hour minimum length of stay for vaginal delivery; 96 hour minimum length of stay for cesarean delivery.	No
Mental/Behavioral Health Outpatient Services	Yes	Mental/Behavioral Health Outpatient Services	Covered	No				No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No

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?
Mental/Behavioral Health Inpatient Services	Yes	Mental/Behavioral Health Inpatient Services	Covered	No				No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No

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?
Substance Abuse Disorder Outpatient Services	Yes	Substance Abuse Disorder Outpatient Services	Covered	No				No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No

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?
Substance Abuse Disorder Inpatient Services	Yes	Substance Abuse Disorder Inpatient Services	Covered	No				No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No
Generic Drugs	Yes	Generic Prescription Drugs	Covered	No				Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No

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?
Preferred Brand Drugs	Yes	Preferred Brand Prescription Drugs	Covered	No				Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
Non-Preferred Brand Drugs	Yes	Non-Preferred Brand Prescription Drugs	Covered	No				Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
Specialty Drugs	Yes	Specialty Prescription Drugs	Covered	No				Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No

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?
Outpatient Rehabilitation Services	Yes	Outpatient Rehabilitation Services	Covered	Yes	20	Visits per year		Non covered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes affecting the voice. No Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except for "Early Intervention Services". No Benefits are available for sport, recreational or occupational reasons. Physical therapy for TMJ disorders is not covered. No Benefits are available for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. Separate 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation services.	No
Habilitation Services	Yes	Habilitation Services	Covered	Yes	20	Visits per year		Non covered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes affecting the voice. No Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except for "Early Intervention Services". No Benefits are available for sport, recreational or occupational reasons. Physical therapy for TMJ disorders is not covered. No Benefits are available for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.	Includes physical therapy, occupational therapy, and speech therapy. Separate 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation services.	No

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?
Chiropractic Care	Yes	Spinal manipulation and manual medical intervention services	Covered	Yes	12	Visits per year		Wellness care is not covered.	Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment; and Medically Necessary diagnostic laboratory and x-ray tests.	No
Durable Medical Equipment	Yes	Medical Equipment and Supplies	Covered	No				No Benefits are available for: Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification; Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds; Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this subsection; Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, items for personal hygiene; Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans; Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems); Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device; Safety equipment, including, but not limited to: hats, belts, harnesses, glasses or restraints; Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system; Self-monitoring devices except as stated in 2 “Medical Supplies” (above), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment; and Dentures, orthodontics, dental prosthesis and appliances. No Benefits are available for appliances used to treat temporomandibular joint (TMJ) disorders.	Benefits are available for durable medical equipment (DME), medical supplies and prosthetic devices.	No

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?
								Convenience Services are not covered, including but not limited to personal comfort items and any equipment, supply or device this is primarily for the convenience of a Member, the Member's family or a Designated Provider. Food and food supplements are not covered except as specified. Nutrition and/or dietary supplements are not covered. Home test kits are not covered.		
Hearing Aids	Yes	Hearing Aids	Covered	Yes	1	Per ear each time prescription changes		No Benefits are available for hearing aids for Members who are 19 years old or older.	Benefits are available for one hearing aid per ear each time a hearing aid prescription changes for Members who are 18 years old or younger.	No
Diagnostic Test (X-Ray and Lab Work)	Yes	Diagnostic Tests	Covered	No				No Benefits are available for diagnostic x-rays in connection with research or study.		No
Imaging (CT/PET Scans, MRIs)	Yes	Advanced Diagnostic Imaging Services	Covered	No						No
Preventive Care/ Screening/ Immunization	Yes	Preventive Care/Screenings and Immunizations	Covered	No					Preventive care that meets the recommendations described in the ACA for plans effective after 9/23/2010 but prior to 8/1/2012.	No
Routine Foot Care	Yes	Routine Foot Care	Covered	No				No Benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered.		No
Acupuncture			Not Covered					No Benefits are available for alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.		
Weight Loss Programs			Not Covered							
Routine Eye Exam for Children	Yes	Routine eye exam and refraction	Covered	Yes	1	Visit per year			Routine eye exam and refraction. Supplemented using FEDVIP.	No
Eye Glasses for Children	Yes	Eye Glasses for Children	Covered	Yes	1	Pair of glasses (lenses and frames) per year			Frames and lenses or contacts. Supplemented using FEDVIP.	No
Dental Check-Up for Children	Yes	Routine Dental Services for Children	Covered	Yes	2	Visits per year			Limitations, including dollar limits, may apply, see EHB benchmark plan documents. Supplemented using FEDVIP.	No
Rehabilitative Speech Therapy	Yes	Rehabilitative Speech Therapy	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	No

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?
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered	No					Quantitative limit units apply, see EHB benchmark plan documents.	No
Well Baby Visits and Care			Not Covered							
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							
Transplant	Yes	Transplant	Covered	No						No
Accidental Dental	Yes	Accidental Dental	Covered	No						No
Dialysis			Not Covered							
Allergy Testing			Not Covered							
Chemotherapy			Not Covered							
Radiation			Not Covered							
Diabetes Education	Yes	Diabetes Education	Covered	No						No
Prosthetic Devices	Yes	Prosthetic Devices	Covered	No					Prosthetic Devices includes artificial limbs.	No
Infusion Therapy			Not Covered							
Treatment for Temporomandibular Joint Disorders	Yes	Treatment for Temporomandibular Joint Disorders	Covered	No						No
Nutritional Counseling			Not Covered							
Reconstructive Surgery	Yes	Reconstructive Surgery	Covered	No						No
Clinical Trials	Yes[S]	Clinical Trials	Covered	No						No

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?
Diabetes Care Management	Yes	Diabetes Care Management	Covered	No						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
Early Intervention Services	Yes	Early Intervention Services	Covered	No						No
Bone Marrow Transplant	Yes	Bone Marrow Transplant	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?
Bone Marrow Testing (HLA) for Donation	Yes	Bone Marrow Testing (HLA) for Donation	Covered	No						No
Diabetes Treatment	Yes	Diabetes Treatment	Covered	No						No
Contraceptive Services	Yes	Contraceptive Services	Covered	No						No
Dental Procedures: Performed At Dental Office	Yes	Dental Procedures: Performed At Dental Office	Covered	No						No
Dental Procedures: Medical or Hospital Group	Yes	Dental Procedures: Medical or Hospital Group	Covered	No						No
Diabetes Services and Supplies	Yes	Diabetes Services and Supplies	Covered	No						No
Mammography & for Testing for Occult Breast Cancer	Yes	Mammography & for Testing for Occult Breast Cancer	Covered	No						No
Mental Health - Biologically Based Mental Illnesses	Yes	Mental Health - Biologically Based Mental Illnesses	Covered	No						No
Mental Health - Mental or Nervous Conditions and Treatment for Chemical Dependency Required	Yes	Mental Health - Mental or Nervous Conditions and Treatment for Chemical Dependency Required	Covered	No						No
Mental Health - Treatment Of Pervasive Developmental Disorder Or Autism	Yes	Mental Health - Treatment Of Pervasive Developmental Disorder Or Autism	Covered	No						No
Nonprescription Enteral Formulas	Yes	Nonprescription Enteral Formulas	Covered	No						No
Pregnancy, Delivery and Postpartum	Yes	Pregnancy, Delivery and Postpartum	Covered	No						No
Prescription Contraceptives	Yes	Prescription Contraceptives	Covered	No						No
Prostheses - Scalp Hair Prostheses	Yes	Prostheses - Scalp Hair Prostheses	Covered	No						No

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?
Reconstruction Surgery as a Result of Mastectomy	Yes	Reconstruction Surgery as a Result of Mastectomy	Covered	No						No
Telemedicine Act	Yes	Telemedicine Act	Covered	No						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	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	11
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
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	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	20
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	11
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	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
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	8
ANTIFUNGALS	NO USP CLASS	25
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
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	5
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
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	12
ANTIVIRALS	ANTIHERPETIC AGENTS	6
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	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
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	10
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	6
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	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	16

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
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	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
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	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	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	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	23
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	4
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	10
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	15
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
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	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	5
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	11