

VIRGINIA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Anthem Health Plans of VA (Anthem BCBS)
Product Name	PPO
Plan Name	KeyCare 30 with KC30 Rx Plan 10 30 50 OR 20
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none">• Pediatric Oral (CHIP)• Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Primary Care Visit to Treat an Injury or Illness	Covered	Primary Care Visit to Treat an Injury or Illness	No					Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
2	Specialist Visit	Covered	Specialist Visit	No					Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit	No					Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Services	No					Oral surgery that is dental in origin; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.		No
5	Outpatient Surgery Physician/Surgical Services	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					Oral surgery that is dental in origin; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.		No
6	Hospice Services	Covered	Hospice Services	No							No
7	Non-Emergency Care When Traveling Outside the U.S.	Covered	Non-Emergency care When Traveling Outside the U.S.	No							No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
8	Routine Dental Services (Adult)	Not Covered	Dental Services						Treatment of natural teeth due to diseases; treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage, unless treatment was sought within 60 days after the injury and you submitted a treatment plan to Anthem for prior approval; dental care, treatment, supplies, or dental x-rays; damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered; oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures; appliances for temporomandibular joint pain dysfunction; or periodontal care, prosthodontal care or orthodontic care; removal of impacted wisdom teeth.		
9	Infertility Treatment	Covered	Infertility Treatment	No					Artificial insemination, in vitro fertilization, other types of artificial or surgical means of conception including drugs administered in connection with these procedures.	Includes services to diagnose and treat conditions resulting in infertility.	No
10	Long-Term/Custodial Nursing Home Care	Not Covered	Long-Term/Custodial Nursing Home Care								
11	Private-Duty Nursing	Covered	Private duty nursing services	Yes	500	Other	\$500 per year		Excludes coverage for private duty nursing services provided in an inpatient setting.	Services of an RN or LPN in the home. Nurse must not be a relative. Doctor must certify that private duty nursing services are medically necessary and not merely custodial. Home nursing services provided through home health care are not subject to this limit.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
12	Routine Eye Exam (Adult)	Covered	Routine Eye Exam	Yes	1	Visits per year			Services for vision training and orthoptics; services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; eyeglasses and eyewear.	Includes routine eye exam and refraction.	No
13	Urgent Care Centers or Facilities	Covered	Urgent Care Services in an Urgent Care Center or Facility	No							No
14	Home Health Care Services	Covered	Home Health Care Services	Yes	100	Visits per year			Homemaker services; maintenance therapy; food and home-delivered meals; custodial care and services.	Medical treatment provided in the home on a part time or intermittent basis including visits by a licensed health care professional, including a nurse, therapist, or home health aide; and physical, speech, and occupational therapy. When these therapy services are provided as part of home health they are not subject to separate visit limits for therapy services.	No
15	Emergency Room Services	Covered	Emergency Room Services	No							No
16	Emergency Transportation/ Ambulance	Covered	Emergency Transportation/ Ambulance	No						Ambulance transportation from home, scene of accident or medical emergency to hospital; between hospitals; between hospital and skilled nursing facility; from hospital or skilled nursing facility to patient's home.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services	No					Convenience items; Private room unless medically necessary; Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No					Care by interns, residents, house physicians or other facility employees that is billed separately from the facility; Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation.	Physician medical and surgical services while in an inpatient facility.	No
19	Bariatric Surgery	Not Covered	Bariatric Surgery						Services and supplies related to obesity or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.		

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
20	Cosmetic Surgery	Not Covered	Cosmetic Surgery						Cosmetic surgery or procedures, including complications that directly result from such surgeries and/or procedures.	Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment.	
21	Skilled Nursing Facility	Covered	Skilled Nursing Facility	Yes	100	Days per admission			Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care.	Items and services provided as an inpatient in a skilled nursing bed of skilled nursing facility or hospital, including room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.	No
22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care	No					Services related to surrogacy is member is not the surrogate.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and All Inpatient Facility and Professional Services for Maternity Care	No				48	Services related to surrogacy is member is not the surrogate.	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
24	Mental/Behavioral Health Outpatient Services	Covered	Mental/Behavioral Health Outpatient Services	No					Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No
25	Mental/Behavioral Health Inpatient Services	Covered	Mental/Behavioral Health Inpatient Services	No					Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No
26	Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Disorder Outpatient Services	No					Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No
27	Substance Abuse Disorder Inpatient Services	Covered	Substance Abuse Disorder Inpatient Services	No					Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs for treatment of alcohol or drug dependence.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
28	Generic Drugs	Covered	Generic Prescription Drugs	No					Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
29	Preferred Brand Drugs	Covered	Preferred Brand Prescription Drugs	No					Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand Prescription Drugs	No					Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
31	Specialty Drugs	Covered	Specialty Prescription Drugs	No					Over the counter drugs; drugs used mainly for cosmetic purposes; Drugs for weight loss; Stop smoking aids, Nutritional and/or dietary supplements.		No
32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services	Yes	30	Visits per year			Physical therapy or occupational therapy to maintain or preserve current function if there is no chance or improvement or reversal; Group or individual exercise classes or personal training sessions; Recreational therapy including but not limited to sleep, dance, arts, crafts, aquatic, gambling and nature therapy.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. 30 visit/year limit for physical and occupational therapy combined. Benefit limits are shared between rehabilitation and habilitation services.	Yes
33	Habilitation Services	Covered	Habilitation Services	Yes	30	Visits per year			Physical therapy or occupational therapy to maintain or preserve current function if there is no chance or improvement or reversal; Group or individual exercise classes or personal training sessions; Recreational therapy including but not limited to sleep, dance, arts, crafts, aquatic, gambling and nature therapy.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. 30 visit/year limit for physical and occupational therapy combined. Benefit limits are shared between rehabilitation and habilitation services.	Yes

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
34	Chiropractic Care	Covered	Spinal manipulation and manual medical intervention services	Yes	30	Visits per year			Spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions.	Benefit limit applies for spinal manipulation and manual medical intervention services.	No
35	Durable Medical Equipment	Covered	Medical Equipment and Supplies	No					Those items that have both a therapeutic and non-therapeutic use including exercise equipment; air conditioners, dehumidifiers, humidifiers and purifiers; hypoallergenic bed linens; whirlpool baths; handrails, ramps, elevators, stair glides; telephones; adjustments made to a vehicle; foot orthotics; changes made to home or place of business; repair or replacement of equipment lost or damaged through neglect. Over the counter convenience and hyenic items that include but are not limited to adhesive removers, cleansers, underpads, ice bags.	Durable medical equipment, medical devices and supplies, prosthetics and appliances, including cochlear implants.	No
36	Hearing Aids	Not Covered	Hearing Aids						Hearing aids, fittings and exams for hearing aids.		
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Tests	No							No
38	Imaging (CT/PET Scans, MRIs)	Covered	Advanced Diagnostic Imaging Services	No							No
39	Preventive Care/ Screening/ Immunization	Covered	Preventive Care/Screenings and Immunizations	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
40	Routine Foot Care	Covered	Routine Foot Care	No						Routine or palliative foot care is covered for treatment of patients with diabetes or vascular disease only; Treatment of bunions only covered when associated with capsular or bone surgery.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
41	Acupuncture	Not Covered	Acupuncture								
42	Weight Loss Programs	Not Covered	Weight Loss Programs						Weight loss programs; Services and supplies related to obesity or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.		
43	Routine Eye Exam for Children	Covered	Routine eye exam	Yes	1	Visits per year					No
44	Eye Glasses for Children	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year)				No
45	Dental Check-Up for Children	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Supplemented by VA CHIP. Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required) : Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Other	Covered	Radiation Therapy	No							No
2	Other	Covered	Chemotherapy	No							No
3	Other	Covered	Infusion Therapy	No							No
4	Other	Covered	Renal Dialysis/ Hemodialysis	No							No
5	Other	Covered	Allergy Treatment	No							No
6	Other	Covered	Injectable drugs and other drugs administered in a provider's office or other outpatient setting	No							No
7	Other	Covered	Early Intervention Services	No						Early intervention services for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of: speech and language therapy; occupational therapy; physical therapy; and assistive technology services and devices.	No

Row Number	A Benefit	B Covered (Required) : Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
8	Other	Covered	Vision Correction After Surgery or Accident	No					Sunglasses or safety glasses and accompanying frames of any type; any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power; any lost or broken lenses or frames; any blended lenses (no line), oversize lenses, polycarbonate lenses (for dependents over the age of 19 and adults), progressive multifocal lenses, photochromatic lenses, Transitions lenses (for dependents over the age of 19 and adults), tinted lenses, coated lenses, anti-reflective coating, cosmetic lenses or processes, or UV-protected lenses; any frame in which the manufacturer has imposed a no discount policy	Prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury. Includes cost of materials and fitting as well as exams and replacement of these eyeglasses or contact lenses if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if: prescribed to replace the human lens lost due to surgery or injury; "pinhole" glasses are prescribed for use after surgery for a detached retina; or lenses are prescribed instead of surgery in the following situations: contact lenses are used for the treatment of infantile glaucoma; corneal or scleral lenses are prescribed in connection with keratoconus; scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.	No
9	Other	Covered	Diabetic Care	No						Palliative foot care, medical supplies, equipment, and education for diabetes care for all diabetics.	No

Row Number	A Benefit	B Covered (Required) : Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
10	Other	Covered	Dental Services for Accidental Injury and Other Related Medical Services	No					Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.	Dental services resulting from an accidental injury provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. The cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth; the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face; dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; dental services to prepare the mouth for radiation therapy to treat head and neck cancer; and covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.	No
11	Other	Covered	Human Organ and Tissue Transplant Services	No					Benefits for donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).	Human organ and tissue transplants are covered when provided as part of physician office services, inpatient facility services, and outpatient facility services. Anthem shall provide benefits for medically necessary human organ and tissue transplant services only when Anthem has preauthorized the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and include medically necessary preparatory myeloablative therapy. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan. Specific limited transportation/lodging costs and donor costs are also covered.	No

Row Number	A Benefit	B Covered (Required) : Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
12	Outpatient Rehabilitation Services	Covered	Speech Therapy	Yes	30	Visits per year				Includes physical therapy, occupational therapy and speech therapy. 30 visit/year speech therapy limit is shared between rehabilitation and habilitation services.	No
13	Habilitation Services	Covered	Speech Therapy	Yes	30	Visits per year				Includes physical therapy, occupational therapy and speech therapy. 30 visit/year speech therapy limit is shared between rehabilitation and habilitation services.	No
14	Other	Covered	Basic Dental Care – Child	No						Supplemented by VA CHIP. Limitations, including dollar limits, may apply.	No
15	Other	Covered	Major Dental Care – Child	No						Supplemented by VA CHIP. Limitations, including dollar limits, may apply.	No
16	Other	Covered	Orthodontia - Child	No						Supplemented by VA CHIP. Members must have a severe, dysfunctional, handicapping malocclusion. Limitations, including dollar limits, may apply.	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	GLUCOCORTICIODS	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	QUINOLONONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBTYRIC 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
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7

CATEGORY	CLASS	SUBMISSION COUNT
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
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

CATEGORY	CLASS	SUBMISSION COUNT
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
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

CATEGORY	CLASS	SUBMISSION COUNT
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
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

CATEGORY	CLASS	SUBMISSION COUNT
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