

## DISTRICT OF COLUMBIA EHB BENCHMARK PLAN

---

### SUMMARY INFORMATION

<b>Plan Type</b>	Plan from largest small group product, Preferred Provider Organization
<b>Issuer Name</b>	Group Hospitalization and Medical Services, Inc.
<b>Product Name</b>	BluePreferred
<b>Plan Name</b>	BluePreferred PPO Option 1
<b>Supplemented Categories</b> (Supplementary Plan Type)	<ul style="list-style-type: none"><li>• Pediatric Oral (FEDVIP)</li><li>• Pediatric Vision (FEDVIP)</li></ul>
<b>Habilitative Services</b> <b>Included Benchmark</b> (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	Office visits for illness or injury	No							No
2	Specialist Visit	Covered	Office visits for illness or injury	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Not Covered									
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient hospital facility services & ambulatory surgical facility services	No							No
5	Outpatient Surgery Physician/Surgical Services	Covered	Outpatient surgery physician/surgical services	No							No
6	Hospice Services	Covered	Hospice services	No							No
7	Non-Emergency Care When Traveling Outside the U.S.	Not Covered									
8	Routine Dental Services (Adult)	Covered	See note on "other" page	No							No
9	Infertility Treatment	Not Covered									
10	Long-Term/Custodial Nursing Home Care	Not Covered									
11	Private-Duty Nursing	Not Covered									
12	Routine Eye Exam (Adult)	Covered	See note on "other" page	No							No
13	Urgent Care Centers or Facilities	Covered	After hours and urgent care centers	No							No
14	Home Health Care Services	Covered	Home health services	No							No
15	Emergency Room Services	Covered	Including voluntary HIV test performed while receiving emergency medical services at hospital ER	No							No
16	Emergency Transportation/Ambulance	Covered	Ambulance service	No							No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient facility services for medical or surgical condition	No							No
18	Inpatient Physician and Surgical Services	Covered	Inpatient professional medical services	No							No
19	Bariatric Surgery	Not Covered									
20	Cosmetic Surgery	Not Covered									
21	Skilled Nursing Facility	Covered	Skilled nursing facility services	No							No
22	Prenatal and Postnatal Care	Covered	Prenatal and postnatal care	No							No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Labor, delivery, and inpatient facility services	No							No
24	Mental/Behavioral Health Outpatient Services	Covered	Mental health outpatient services	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
25	Mental/Behavioral Health Inpatient Services	Covered	Mental health inpatient services	No							No
26	Substance Abuse Disorder Outpatient Services	Covered	Substance abuse outpatient services	No							No
27	Substance Abuse Disorder Inpatient Services	Covered	Inpatient substance abuse facility and professional services	No							No
28	Generic Drugs	Covered	Generic drugs	No							No
29	Preferred Brand Drugs	Covered	Preferred brand name drugs	No							No
30	Non-Preferred Brand Drugs	Covered	Non-preferred brand name drugs	No							No
31	Specialty Drugs	Covered	Prescription, maintenance drugs covered	No							No
32	Outpatient Rehabilitation Services	Covered	Occupational therapy, physical therapy, speech therapy	No							No
33	Habilitation Services	Covered	Defined in DC Code for children 21 and under	No							No
34	Chiropractic Care	Not Covered									
35	Durable Medical Equipment	Covered	Durable Medical Equipment	No							No
36	Hearing Aids	Not Covered									
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Laboratory tests, x-rays, and other diagnostic procedures	No							No
38	Imaging (CT/PET Scans, MRIs)	Covered	Outpatient x-rays and major diagnostics, including MRI, MRA, and nuclear medicine	No							No
39	Preventive Care/Screening/Immunization	Covered	Preventative care/screening/immunization	No							No
40	Routine Foot Care	Not Covered									
41	Acupuncture	Not Covered									
42	Weight Loss Programs	Covered	Obesity preventative services and weight management drugs.	No							No
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 other	1 pair of glasses (lenses and frames per year				No
45	Dental Check-Up for Children	Covered	Dental Exams	Yes	1	Other other	1 every 6 months				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	Dialysis	No							No
2	Other	Covered	Allergy Injections	No							No
3	Other	Covered	Speech Therapy	No							No
4	Other	Covered	Radiation Therapy	No							No
5	Other	Covered	Chemotherapy	No							No
6	Other	Covered	Blood, Blood Products, and Administration	No							No
7	Other	Covered	Transplant Services	No							No
8	Other	Covered	Postpartum Home Visits	No							No
9	Other	Covered	Detoxification	No							No
10	Other	Covered	Internal Prosthetics	No							No
11	Other	Covered	External Prosthetics- Breast prostheses, Mastectomy Bras	No							No
12	Other	Covered	External Prosthetics- Ostomy and Urological Supplies	No							No
13	Other	Covered	Routine Gynecological Exam	No							No
14	Other	Covered	Prostate Cancer Screening	No							No
15	Other	Covered	Pap Smear	No							No
16	Other	Covered	Mammography	No							No
17	Other	Covered	Correctol Cancer Screening	No							No
18	Other	Covered	Medical Nutrition Therapy	No							No
19	Other	Covered	Professional Nutrition Counseling	No							No
20	Other	Covered	Hair Prosthesis	No							No
21	Routine Dental Services (Adult)	Covered	Covered, but under an optional plan rider.	No							No

**PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS**

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	6
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	8
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICIODS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANTIBACTERIALS	AMINOGLYCOSIDES	4
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	10
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	8
ANTIBACTERIALS	BETA-LACTAM, OTHER	0
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	3
ANTIBACTERIALS	QUINOLONES	4
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	3
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	3
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	6
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	7
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	7
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	4
ANTIFUNGALS	NO USP CLASS	13
ANTIGOUT AGENTS	NO USP CLASS	4
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	2
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	1
ANTIMYCOBACTERIALS	ANTITUBERCULARS	5
ANTINEOPLASTICS	ALKYLATING AGENTS	5
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	1
ANTIPARASITICS	ANTIPROTOZOALS	6
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	3
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	1
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	1
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	9
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	1
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	2
ANTIVIRALS	ANTIHEPATITIS AGENTS	5
ANTIVIRALS	ANTIHERPETIC AGENTS	4
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	4

<b>CATEGORY</b>	<b>CLASS</b>	<b>SUBMISSION COUNT</b>
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	5
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	15
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	0
BLOOD GLUCOSE REGULATORS	INSULINS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	4
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	5
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	7
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	12
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	3
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	3
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	5
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON- AMPHETAMINES	2
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	0
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	0
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	2
DENTAL AND ORAL AGENTS	NO USP CLASS	5
DERMATOLOGICAL AGENTS	NO USP CLASS	16
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	1
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	3
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	3
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

<b>CATEGORY</b>	<b>CLASS</b>	<b>SUBMISSION COUNT</b>
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	0
GASTROINTESTINAL AGENTS	LAXATIVES	1
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	3
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	3
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	7
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	1
GENITOURINARY AGENTS	PHOSPHATE BINDERS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICIDS/MINERALOCORTICIDS	20
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	0
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	9
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	3
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	6
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	2
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4



<b>CATEGORY</b>	<b>CLASS</b>	<b>SUBMISSION COUNT</b>
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	7
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12
OTIC AGENTS	NO USP CLASS	3
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	4
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	9
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	6
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	1
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	1
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	1
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	2