KENTUCKY EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Anthem Health Plans of KY (Anthem BCBS)
Product Name	PPO
Plan Name	Anthem PPO
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (State CHIP)
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; 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; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; elective abortions; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.		No

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5	**Outpatient Surgery Physician/Surgical Services**	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					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; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; elective abortions; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.		No
6	**Hospice Services**	Covered	Hospice Services	No					Services provided by volunteers; housekeeping services.		No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency care When Traveling Outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Not Covered	Dental Services						Treatment of natural teeth due to diseases; dental care, treatment, supplies, or dental x-rays; damage to 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**	Not Covered	Infertility Treatment						Diagnostic testing or treatment related to infertility; Artificial insemination, in vitro fertilization, other types of artificial or surgical means of conception including drugs administered in connection with these procedures.		
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered	Long-Term/Custodial Nursing Home Care								

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11	**Private-Duty Nursing**	Covered	Private duty nursing services	Yes	2000	Hours per year			Private duty nursing services in an inpatient setting.	Home nursing services provided through home health care. Limit applies to private duty nursing in home setting.	No
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam	No					Services for vision training and orthoptics; 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			Food, housing, homemaker services and home delivered meals; home or outpatient hemodialysis services; physician charges; helpful environmental materials; Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider; Services provided by a member of the patient's immediate family; Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities; Manipulation therapy services rendered in the home.	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					Care received in and emergency room that is not emergency care.		No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/Ambulance	No					Non covered services for ambulance include but are not limited to, trips to a physician's office or clinic, a morgue or a funeral home.	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

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No					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; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; elective abortions; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	Yes
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No					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; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; elective abortions; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	Yes

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19	**Bariatric Surgery**	Not Covered	Bariatric Surgery						Bariatric surgery, regardless of the purpose it is proposed or performed. This includes Roux-en-Y(RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure.		

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20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery						For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgeries, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/ self-funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery.		
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	90	Days per year			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

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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
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	Yes	30	Visits per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Residential treatment services also covered. 30 visits per benefit period for outpatient mental health and substance abuse combined.	No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	Yes	30	Days per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Residential treatment services are also covered. 30 days per benefit period for inpatient mental health and substance abuse combined.	No

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26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	Yes	30	Visits per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Residential treatment services are also covered. 30 visits per benefit period for outpatient mental health and substance abuse combined.	Yes
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	Yes	30	Days per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Residential treatment services are also covered. 30 days per benefit period for inpatient mental health and substance abuse combined.	Yes
28	**Generic Drugs**	Covered	Generic Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No

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30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No
31	**Specialty Drugs**	Covered	Specialty Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No

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32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	20	Visits per year			(Physical Therapy) Non Covered Services include: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. (Occupational Therapy) Non Covered Services include: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment. (Cardiac Rehab) Home programs, on-going conditioning and maintenance are not covered. (Pulmonary Rehab) Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.	Includes physical therapy, occupational therapy, speech therapy, pulmonary therapy and cardiac rehabilitation. Separate 20 visit limit for PT, OT, ST, Pulmonary Rehab; 36 visit limit for Cardiac Rehab. Benefit limits are shared between rehabilitation and habilitation services.	Yes

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33	**Habilitation Services**	Covered	Habilitation Services	Yes	20	Visits per year				Includes physical therapy, occupational therapy, speech therapy. Separate 20 visit limit for PT, OT, ST. Benefit limits are shared between rehabilitation and habilitation services.	No
34	**Chiropractic Care**	Covered	Spinal manipulation and manual medical intervention services	Yes	12	Visits per year			Manipulation therapy services rendered in the home as part of Home Care Services are not covered.	Benefit limit applies for spinal manipulation and manual medical intervention services.	No

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35	**Durable Medical Equipment**	Covered	Medical Equipment and Supplies	No					Non covered services include: Items for personal hygiene, environmental control or convenience; Exercise equipment; (Repairs and replacement) Repair and replacement due to misuse, malicious breakage or gross neglect. Replacement of lost or stolen items. (Medical and Surgical Supplies) Adhesive tape, band aids, cotton tipped applicators; Arch supports; Doughnut cushions; Hot packs, ice bags; vitamins; medijectors (Durable Medical Equipment) Air conditioners; Ice bags/ coldpack pump; Raised toilet seats; Rental of equipment if the Member is in a Facility that is expected to provide such equipment; Translift chairs; Treadmill exerciser; Tub chair used in shower. (Prosthetics) Dentures, replacing teeth or structures directly supporting teeth; Dental appliances; Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets; Artificial heart implants; Wigs (except following cancer treatment); Penile prosthesis in men suffering impotency resulting from disease or injury (Orthotics) Orthopedic shoes (except therapeutic shoes for diabetics); Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace; Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies); Garter belts or similar devices.	Durable medical equipment, medical devices and supplies, prosthetics and appliances, including cochlear implants	No
36	**Hearing Aids**	Covered	Hearing Aids	Yes	1	Other	1 time/ hearing impaired ear every 36 months		Hearing aids, fittings and exams for hearing aids, for other than under age 18.	Covered for Member under 18 years of age no more than one time per hearing impaired ear every 36 months.	No
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Tests	No							No

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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.	No
40	**Routine Foot Care**	Not Covered	Routine Foot Care						Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including: cleaning and soaking the feet; applying skin creams in order to maintain skin tone; other services that are performed when there is not a localized illness, injury or symptom involving the foot.	Palliative or cosmetic foot care	
41	**Acupuncture**	Not Covered	Acupuncture						Services or supplies related to alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.		
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs						Weight loss programs, whether or not they are pursued under medical or physician supervision.		
43	**Routine Eye Exam for Children**	Covered	Routine eye exam and refraction	No					Services for vision training and orthoptics; limited to children under age 21.	Includes routine eye exam and refraction; based on the Kentucky CHIP option; limited to one visit per year.	No
44	**Eye Glasses for Children**	Covered	Eye Glasses for Children	No					Limited to children under age 21.	Based on the KY CHIP option; limited to One Pair of eyeglasses per year.	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
45	**Dental Check-Up for Children**	Covered	Routine Dental Services for Children	Yes	2	Visits per year	Cleanings per year			Based on the KY CHIP option Services for Children under 21 to include: 2 cleanings per 12-month period; extractions and fillings	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	Biofeedback	No							No
8	**Other**	Covered	Autism Services	Yes	20	Other	20 hours per month		Services for which member has no legal obligation to pay; Services provided by a publicly funded program; Services performed by a relative of the member for which, in the absence of any health benefit coverage, no charge would be made; Services provided by persons who are not licensed as required by law.	KY State Mandate: Services for Autism Spectrum Disorders including Medical Care, Habilitative or Rehabilitative care, Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied Behavior Analysis.	No
9	**Other**	Covered	Vision Correction After Surgery or Accident	No					Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service.	Prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury.	No
10	**Other**	Covered	Medical supplies, equipment, and education for diabetes care for all diabetics	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
11	**Other**	Covered	Dental Services for Accidental Injury and Other Related Medical Services	Yes	3000	Other	dollars/benefit period		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 when treatment is performed within 12 months after the injury. The benefit limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that we are required by law to cover. Coverage includes oral examinations, x-rays, tests and laboratory examinations, restorations, prosthetic services, oral surgery, mandibular/ maxillary reconstruction, anesthesia. Other covered dental services include anesthesia and hospital or facility charges in connection with dental procedures for dependents below the age of nine years, members with serious mental or physical conditions, and members with significant behavioral problems. The only other dental expenses covered are facility charges for Outpatient services for the removal of teeth or for other dental processes if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.	No
12	**Other**	Covered	Human Organ and Tissue Transplant Services	No						Medically necessary human organ and tissue transplant services. 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. Additional covered services include unrelated donor searches and transportation and lodging.	No

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13	**Other**	Covered	Human Organ and Tissue Transplant Services - Transportation and Lodging	Yes	10000	Other	$10000/transplant benefit paid		Non covered transportation and lodging includes child care; mileage within the transplant city; rental cars, buses, taxis or shuttle service, except as specifically approved; frequent flyer miles; coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transplant; telephone calls; laundry; postage; entertainment; interim visits to a medical facility while waiting for the actual transplant procedure; travel expenses for donor companion/ caregiver; return visits for the donor for a treatment of a condition found during evaluation.	The Plan will provide assistance with reasonable and necessary travel expenses when patient is required to travel more than 75 miles from residence to reach the facility where the Covered Transplant Procedure will be performed. Assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.	No
14	**Other**	Covered	Human Organ and Tissue Transplant Services - Unrelated donor search	Yes	1	Other	one per benefit period				No
15	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Rehab Facilities Including Room & Board Charges, Physician Fees, Imaging, Testing, and Supplies	Yes	60	Days per year					Yes
16	**Inpatient Physician and Surgical Services**	Covered	Rehab Facilities Including Room & Board Charges, Physician Fees, Imaging, Testing, and Supplies	Yes	60	Days per year					Yes
17	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	Yes	2	Treatments per lifetime				Two Inpatient & Outpatient Substance Abuse rehabilitation programs per lifetime.	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
18	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	Yes	2	Treatments per lifetime				Two Inpatient & Outpatient Substance Abuse rehabilitation programs per lifetime.	No
19	**Outpatient Rehabilitation Services**	Covered	Cardiac Rehabilitation	Yes	36	Visits per year					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
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
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
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
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	3
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	4
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	22
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
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

CATEGORY	CLASS	SUBMISSION COUNT
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