NEW JERSEY EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	Horizon HMO
Product Name	HMO
Plan Name	Horizon HMO Access HSA Compatible
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State 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							No
2	**Specialist Visit**	Covered	Specialist visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other practitioner office visits (nurse, physician assistant)	No					Care and/or treatment by a Christian Science practitioner or care by a family member.	Practitioner must be licensed and acting within the scope of the license, but also cover services of BCBA and BCaBA practitioners.	No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient facility fee	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient surgery; physician/surgical services	No					Local anesthesia billed separately when charges are included in surgery fee.	Pre-approval required.	No
6	**Hospice Services**	Covered	Hospice services	No					Private accommodations.	Inpatient hospice covered at the private room & board rate. Pre-approval required.	No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Not Covered	Travel outside U.S.								
8	**Routine Dental Services (Adult)**	Not Covered	Routine dental-adult (see explanation)							See "Other" for covered dental-related services.	
9	**Infertility Treatment**	Covered	Limited infertility treatment	No					Services or supplies to enhance fertility that involve harvesting, storage and/or manipulation of eggs and sperm, including in vitro fertilization, embryo transfer, embryo freezing, gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), donor sperm, surrogate motherhood, or sterilization reversal.	Pre-approval required. Except as specifically excluded, only artificial insemination and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs are covered.	No
10	**Long-Term/Custodial Nursing Home Care**	Not Covered	LTC/Custodial						Custodial and domiciliary care		

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	**Private-Duty Nursing**	Covered	Covered as part of home health benefits only	Yes	60	Visits per year				Only covered under Home Health Care Services (see Home Health Care for other limits/conditions).	No
12	**Routine Eye Exam (Adult)**	Covered	Routine eye exam - adult (see exclusion/explanation)	No					Exams to determine the need for or changes of eyeglasses or lenses; eyeglasses or lenses of any type (other than initial replacements of the natural lens); eye surgery primarily intended to correct myopia, hyperopia or astigmatism.	Eye screenings provided as part of a routine physical exam are covered.	No
13	**Urgent Care Centers or Facilities**	Covered	Urgent care centers or facilities	No							No
14	**Home Health Care Services**	Covered	Home health care services	Yes	60	Visits per year	Visit limit is per calendar year		Services furnished to family members, other than the patient. Services and supplies not included in the home health care plan.	Pre-approval required. Covers medically necessary and appropriate services in a written home health plan when certified as needed to avoid continuing hospitalization or confinement in a SNF. Services and supplies must be included in the written plan and furnished by a home health agency through recognized health care professionals. The covered person's practitioner must establish the written plan within 14 days after home health care starts and review it at least once every 60 days.	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
15	**Emergency Room Services**	Covered	Emergency room services	No						No referral or notice required prior, but coverage is provided only if written proof of the occurrence, nature and extent of the emergency service is submitted within 30 days. Coverage for emergency services includes only treatment needed to treat the emergency; pre-approval is required for coverage of elective procedures performed after admission as a result of an emergency. Emergency services of non-network providers covered only if it is determined the covered person's symptoms were severe and delay of treatment would have been detrimental to health, the symptoms occurred suddenly and the covered person sought immediate attention, and the service or supply is not normally provided on a non-emergency basis. Includes emergency room treatment at Level 1 and Level 2 trauma centers (as required by NJAC 11:24A-2.6).	No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency transportation/ambulance	No					Chartered flights. Travel or communication expenses of patients, health care providers or family members. Services for ambulance transport from a hospital to another facility except when a member is transferred to another inpatient health care facility.	Covers medically necessary and appropriate charges for transporting a member to a local hospital or to the nearest hospital where needed care can be given, if a local hospital cannot provide such care (but see exclusion).	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					Private accommodations	Pre-approval required. Covered at semi-private room and board rate. Includes nursing, intensive and special care facilities, imaging and laboratory services, drugs and biologicals, pre- and post-operative care, anesthesia, blood, surgical, medical and obstetrical services, etc.	No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient physician and surgical services	No					Local anesthesia charges if billed separately when charges are included in the fee for the surgery.	Pre-approval required for surgery.	No
19	**Bariatric Surgery**	Covered	Bariatric surgery	No						Pre-approval required.	No
20	**Cosmetic Surgery**	Not Covered	See Exclusion and Explanation						Cosmetic surgery, treatment for complications of cosmetic surgery, related services or supplies and drugs provided for cosmetic purposes.	Defined as any surgery or procedure that involves physical appearance that does not correct or materially improve a physiological function and is not medically necessary.	
21	**Skilled Nursing Facility**	Covered	Skilled nursing facility	No					Private accommodations.	Pre-approval required. Coverage of network SNF services and supplies only for those constituting skilled nursing care.	No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and postnatal care	No						See "Delivery and All Inpatient Services for Maternity Care." Mother may elect a home care program in lieu of the post-delivery hospital stay.	No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and all inpatient services for maternity care	No				48	Private accommodations.	Mother and newborn may be covered up to 48/96 hours inpatient in a network hospital after a vaginal/caesarian delivery if the attending physician determines it is medically necessary or the mother requests it.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/behavioral health outpatient services	No					Custodial care, education and training.	See also "Other" for Autism and Developmental Disabilities.	No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/behavioral health inpatient services	No					Private accommodations, custodial care, education and training.	Pre-approval required.	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
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance abuse disorder outpatient services	No					Custodial care, education and training.		No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance abuse disorder inpatient services	No					Private accommodations, custodial care, education and training.	Pre-approval required.	No
28	**Generic Drugs**	Covered	Generic drugs	No					Drugs prescribed for cosmetic purposes; nonprescription drugs.	Covered per prescription/refill for up to a 90-day supply or 100 unit doses, or the amount usually prescribed by the Network practitioner. Additional limits may apply based on FDA approved product labeling. See "Other" for additional Prescription Drug information.	No
29	**Preferred Brand Drugs**	Covered	Preferred brand drugs	No					Drugs prescribed for cosmetic purposes; nonprescription drugs.	Covered per prescription/refill for up to a 90-day supply or 100 unit doses, or the amount usually prescribed by the Network practitioner. Additional limits may apply based on FDA approved product labeling. Pre-approval required for certain prescription drugs. See "Other" for additional Prescription Drug information.	No
30	**Non-Preferred Brand Drugs**	Covered	Non-preferred brand drugs	No					Drugs prescribed for cosmetic purposes; nonprescription drugs.	Covered per prescription/refill for up to a 90-day supply or 100 unit doses, or the amount usually prescribed by the Network practitioner. Additional limits may apply based on FDA approved product labeling. Pre-approval required for certain prescription drugs. See "Other" for additional Prescription Drug information.	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
31	**Specialty Drugs**	Covered	Specialty drugs	No					Drugs prescribed for cosmetic purposes; nonprescription drugs.	All specialty drugs require pre-approval. Defined as drugs that have unique production, administration or distribution requirements, and require specialized patient education prior to use and ongoing patient assistance while under treatment. Must be dispensed through specialty pharmaceutical providers. See "Other" for Hemophilia services as well as Anti-cancer Prescription Drugs.	No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient rehabilitation services	Yes	30	Visits per year				Pre-approval required. Separate from services provided through home health care benefits.	No
33	**Habilitation Services**	Covered	Habilitation services	Yes	1	Other	Habilitation services are subject to the limits applicable to rehabilitation services, other therapies, services and supplies. See Explanation.			Habilitations as provided through rehabilitation services are covered. See also: Hearing Aids; "Other" for Autism and Developmental Disabilities benefits, ST, PT/OT and ABA benefits; "Other" for Diabetes services.	No
34	**Chiropractic Care**	Covered	Therapeutic manipulation	Yes	30	Visits per year				Covered when therapeutic manipulation is provided in a network practitioner's office, for no more than two modalities per visit.	No
35	**Durable Medical Equipment**	Covered	Durable medical equipment	No						Pre-approval required, must be ordered by a network practitioner [and arranged through the carrier].	No
36	**Hearing Aids**	Covered	Hearing aids	Yes	2	Other	One/hearing-impaired ear every 24-months			Covered for members 15 years old and younger. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.	No
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic test (X-ray and lab work)	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
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET scans, MRIs)	No						Pre-approval required, including for: CT, PET, MRI, Computed Tomography Angiography (CTA), Magnetic Resonance Angiogram (MRA), Nuclear Medicine (including Nuclear Cardiology).	No
39	**Preventive Care/ Screening/Immunization**	Covered	Preventive care/screening/immunization	No					Routine immunizations for the sole purpose of travel or as a requirement for a member's employment.	Includes USPSTF recommendations, but see "Other" for additional screening benefits.	No
40	**Routine Foot Care**	Not Covered	See Explanation							Routine foot care is excluded, except for the following: open cutting operations to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; removal of nail roots; treatment of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease. Also, see "Other" for Orthotics and Prosthetics benefits.	
41	**Acupuncture**	Not Covered	See Explanation							Covered when used as a substitute for other forms of anesthesia.	
42	**Weight Loss Programs**	Not Covered									
43	**Routine Eye Exam for Children**	Covered	Routine eye exam for children	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eye glasses for children	Yes	1	Other	Allowance for eyeglasses (lenses and frames) or contact lenses annually.		Does not provide allowance for both glasses and contacts in a single year. No vision therapy; no other corrective treatments or devises, except as described (see "Explanation").	Includes coverage for exams by optometrist or ophthmalogist, including dilation. Includes allowances for lenses, frames, contacts, and discounts for laser surgery when using a contracted provider.	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	Dental Services (per CHIP)	No					Treatment for TMJ; limited to members age 19 and younger.	Coverage includes screenings and other preventive services, diagnostic services, major and minor restorative services, endodontic, surgical and adjunctive services, periodontic and prosthedontic services, as medically necessary. Begins at age 1 year. Dental services also include orthodontia—see "Other."	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	Speech and Cognitive therapy	Yes	30	Visits per year	Combined=30/calendar year			Limit only applies when provided in a network practitioner's office—services provided under Home Health Care or to treat Autism or Developmental Disabilities do not apply towards this limit. Also note: the benefit limit for the standard small group plans is combined for speech and cognitive therapy for a total of 30 visits, but for the standard individual plan market, the limit is 30 visits each for speech and cognitive therapy.	Yes
2	**Other**	Covered	Physical and Occupational therapy	Yes	30	Visits per year	Combined=30/calendar year			Limit only applies when provided in a network practitioner's office—services provided under Home Health Care or to treat Autism or Developmental Disabilities do not apply towards this limit. Also note: the benefit limit for the standard small group plans is a combined 30 visit limit for PT and OT, but for the standard individual market, the benefit limit is 30 visits each for PT and OT.	No
3	**Other**	Covered	Autism/Developmental Disabilities - Speech therapy (Habilitative/rehabilitative)	Yes	30	Visits per year	visits per calendar year			Limit does not apply against other ST benefits under the policy. Only available for treatment of diagnosis of autism or developmental disability. Therapy need not be restorative. Therapy received through Early Intervention Services does not reduce these therapy benefits.	No
4	**Other**	Covered	Autism/Developmental Disabilities - Physical and Occupational therapy (Habilitative/rehabilitative)	Yes	30	Visits per year	Combined=30/calendar year			Limit does not apply against other PT/OT benefits under the policy. Only available for treatment of diagnosis of autism or developmental disability. Therapy need not be restorative. Therapy received through Early Intervention Services does not reduce these therapy benefits.	No
5	**Other**	Covered	Autism/Developmental Disabilities - Applied Behavior Analysis or Related Structured Behavior Services (Habilitative/rehabilitative)	No						For members <21 years old. Available to treat primary diagnosis of autism. Therapy need not be restorative. Therapy received through Early Intervention Services does not reduce any benefit. Treatment plan by physician required, reviewed semi-annually.	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
6	**Other**	Covered	Food/Food Products for Inherited Metabolic Diseases	No						Coverage for charges incurred for medical foods (enteral formulas) and low protein modified food products as determined medically necessary by the member's practitioner for the therapeutic treatment of inherited metabolic diseases.	No
7	**Other**	Covered	Specialized non-standard infant formula	No						For infants and toddlers. Covered as if a prescription drug for children diagnosed with multiple food protein intolerance for whom the formula is medically necessary and for whom trials of other non-cow milk-based formulas have not been successful.	No
8	**Other**	Covered	Blood, blood products and blood transfusions	No					Blood donated or replaced on behalf of a member.	Includes the cost of testing and processing of blood. See also "Hemophilia Services."	No
9	**Other**	Covered	Dental Care and Treatment -- Illness and injury	No					General dental services, both prophylactic and corrective.	Covered: diagnosis and treatment of oral tumors and cysts; surgical removal of bony impacted teeth; treatment of an injury to natural teeth or the jaw, including replacing natural teeth, if the injury was not caused (directly or indirectly) by biting or chewing, and all treatment is complete w/in 6 months from date of injury. Includes related dental ex-rays.	No
10	**Other**	Covered	Dental Care and Treatment -- Anesthesia	No					Anesthesia for dental services other than an described under "Explanation"	Covered: when a member is severely disabled or a child under age six, general anesthesia and hospitalization for dental services, and dental services rendered by a dentist regardless of where provided when for a medical condition requiring hospitalization or general anesthesia.	No
11	**Other**	Covered	Temporomandibular Joint Disorder	No					Services or supplies for orthodontia, crowns or bridgework.	Surgical and nonsurgical treatment of TMJ is covered when medically necessary and appropriate.	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	**Other**	Covered	Cancer Clinical Trials	No					Costs of investigational drugs or devices, costs of non-health services, costs related to managing the research, any costs that would not be covered for treatments that are not Experimental or Investigational.	Fees and expenses are covered for treatment of a condition associated with a complication of the underlying disease (cancer) through an Approved Cancer Clinical Trial if such fees and expenses would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.	No
13	**Other**	Covered	Pain Management Services	No						Pre-approval required.	No
14	**Other**	Covered	Chelation therapy	No						Must be rendered by an appropriately licensed Network provider.	No
15	**Other**	Covered	Chemotherapy	No						Must be rendered by an appropriately licensed Network provider.	No
16	**Other**	Covered	Dialysis Treatment	No						Includes both hemodialysis and peritoneal dialysis and treatment in a dialysis center by an appropriately licensed network provider.	No
17	**Other**	Covered	Radiation therapy	No						Treatment of disease; diagnostic service requiring use of radioactive materials is not considered radiation therapy. Includes rental or cost of radioactive materials.	No
18	**Other**	Covered	Respiration therapy	No						Treatment by a network provider that introduces dry or moist gases into the lungs.	No
19	**Other**	Covered	Infusion therapy	No						Treatment involving the administration of antibiotics, nutrients, or other therapeutic agents by direct infusion. Pre-approval required. See also "Hemophilia" benefits; infusion therapy is not limited to hemophilia treatment.	No
20	**Other**	Covered	Transplants: cornea, kidney, lung, liver, heart, pancreas, intestine, allogenic bone marrow	No						Costs associated with the transplant, including inpatient services, and practitioner services.	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
21	**Other**	Covered	Transplants: autologous bone marrow transplant	No						Inpatient hospital services and practitioner services, including associated dose-intensive chemotherapy, but only if performed by institutions approved by the NCI, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.	No
22	**Other**	Covered	Transplants: peripheral blood stem cells	No						Inpatient hospital and practitioner services, but only if performed by institutions approved by the NCI or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.	No
23	**Other**	Covered	Transplants: donor costs	No					Travel, accommodations, or comfort items.	Inpatient hospital costs of donors associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor.	No
24	**Other**	Covered	Hemophilia services	No						Home treatment services for bleeding episodes are covered, including blood, blood products (factors), infusion equipment, and training. Clinical laboratory services at state-designated regional care centers are covered under certain circumstances whether or not the facility is in-network.	No
25	**Other**	Covered	Orthotics and prosthetics	No						Covered if the member's practitioner determines it is medically necessary, and obtained from a licensed orthotist, prosthetist or certified pedorthist in-network.	No
26	**Other**	Covered	Newborn hearing screening	No						Electrophysiologic screening covered during first 28 days after birth. Periodic monitoring for delayed onset hearing loss covered from age 29 days through 36 months after birth.	No
27	**Other**	Covered	mammograms	No						Includes a base line mammogram from ages 35-39; covers annual mammograms from age 40 on, or at younger ages if a women is at risk.	No
28	**Other**	Covered	Lead screening, follow-up treatment of high levels of lead in blood	No						Required during childhood.	No
29	**Other**	Covered	Mastectomy inpatient stay	No				48			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
30	**Other**	Covered	Reconstructive breast surgery	No						Pre-approval required. Surgery to restore and achieve symmetry, and/or cost of prostheses following a mastectomy on one or both breasts; treatment of physical complications, including lymphedemas.	No
31	**Other**	Covered	Diabetes Treatment -- services and supplies	No						Coverage for self-management education and nutrition counseling as medically necessary; coverage for insulin syringes and insulin needles; glucose test strips; lancets; pumps and infusers, drugs, etc.	No
32	**Other**	Covered	nutritional counseling	No						For management of disease with specific criteria that can be verified (including diabetes); see also Diabetes services	No
33	**Other**	Covered	Prescription drugs -- contraceptives	No						Prescribed female contraceptives. Religious employers may request exclusion of the benefit.	No
34	**Other**	Covered	Prescription drugs -- off label	No						Coverage must be provided for off-label prescriptions when certain protocols are met.	No
35	**Other**	Covered	Prescription drugs -- open formulary and mail order restrictions	No						It is impermissible to require use of mail order only; it is impermissible to impose closed formularies.	No
36	**Other**	Covered	Anti-cancer Prescription Drugs	No						Orally administered anti-cancer prescription drugs must be covered on a basis at least as favorable as intravenously administered or injected anti-cancer medications.	No
37	**Other**	Covered	Orthodontia (per CHIP)	No					Cosmetic orthodontia.	Coverage is limited to demonstration of at least one of the following: severe functional difficulties; developmental anomalies of facial bones and/or oral structure; facial trauma resulting in severe functional difficulties; or that psychological health requires orthodontic correction. Generally, coverage is limited to prevent or correct facial deformities, or functional difficulties in speech or mastication.	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	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	9
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	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	16
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	12
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	6
ANTIBACTERIALS	MACROLIDES	4
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	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	7
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	9
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	6
ANTIFUNGALS	NO USP CLASS	19
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3

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	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	3
ANTIPARASITICS	ANTHELMINTICS	3
ANTIPARASITICS	ANTIPROTOZOALS	11
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
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	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
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	5
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	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	7
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
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	5
DENTAL AND ORAL AGENTS	NO USP CLASS	6
DERMATOLOGICAL AGENTS	NO USP CLASS	31
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
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	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	8
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	16
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	8
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	11
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	9
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	4
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	4
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	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	5