GEORGIA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Point of Service
Issuer Name	BCBS Healthcare Plan of Georgia, Inc.
Product Name	POS
Plan Name	HMO Urgent Care 60 Copay
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes
Habilitative Services Defined by State (Yes/No)	No

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 Visit	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility Services	No					Corrective eye surgery; Reversal of voluntary sterilization; Oral surgery that is dental in nature; Sexual Modification/Dysfunction Treatments - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).		No
5	**Outpatient Surgery Physician/ Surgical Services**	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					Corrective eye surgery; Reversal of voluntary sterilization; Oral surgery that is dental in nature; Sexual Modification/Dysfunction Treatments - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).		No
6	**Hospice Services**	Covered	Hospice Services	No							No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Not Covered	Non-Emergency care When Traveling Outside the U.S.						Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.		

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8	**Routine Dental Services (Adult)**	Not Covered	Dental Services						Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered.		
9	**Infertility Treatment**	Covered	Infertility Treatment	No					Artificial insemination, in vitro fertilization, other types of artificial or surgical means of conception including drugs administered in connection with these procedures.	Includes services to diagnose and treat conditions resulting in infertility.	No
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered	Long-Term/ Custodial Nursing Home Care						Benefits will not be provided when: A Member reaches the maximum level of recovery possible and no longer requires other than routine care; Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service; Care is for chronic brain syndromes for which no specific medical conditions exist that require care in a Skilled Nursing Facility; A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care; The care rendered is for other than Skilled Convalescent Care.		
11	**Private-Duty Nursing**	Not Covered	Private duty nursing services						Inpatient private duty nursing is not covered. Home private duty nursing is not covered.		
12	**Routine Eye Exam (Adult)**	Not Covered	Routine Eye Exam						Eye exam and refraction; Services for vision training and orthoptics; eyeglasses and eyewear.		
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Services at Urgent Care Center or Facility	No							No

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14	**Home Health Care Services**	Covered	Home Health Care Services	Yes	120	Visits per year			Covered Services for Home Health do not include: Food, housing, homemaker services, sitters, home-delivered meals; Home Health Care services which are not Medically Necessary or of a non-skilled level of care. Services of a person who ordinarily resides in the patient's home or is a member of the family of either the patient or patient's spouse. Any services for any period during which the Member is not under the continuing care of a Physician. Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient. Any services or supplies not specifically listed as Covered Services. Routine care and/or examination of a newborn child. Dietitian services. Maintenance therapy. Dialysis treatment. Purchase or rental of dialysis equipment. Private duty nursing care.	Medical treatment provided in the home on a part time or intermittent basis including visits by a licensed health care professional, including a nurse, therapist, or home health aide; and physical, speech, and occupational therapy. When these therapy services are provided as part of home health they are not subject to separate visit limits for therapy services.	No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No						Ambulance transportation from home, scene of accident or medical emergency to hospital; between hospitals; between hospital and skilled nursing facility; from hospital or skilled nursing facility to patient's home.	No

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No					Inpatient Rehabilitation - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or: the treatment is for maintenance therapy; or the Participant has no restorative potential; or the treatment is for congenital learning or neurological disability/disorder; or the treatment is for communication training, educational training or vocational training. Personal Comfort Items - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies. Private Room - Private room, except as specified as Covered Services. Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under Covered Services. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw). Corrective eye surgery; Reversal of voluntary sterilization; Oral surgery that is dental in nature; Sexual Modification/Dysfunction Treatments - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	No

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18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No					Inpatient Rehabilitation - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or: the treatment is for maintenance therapy; or the Participant has no restorative potential; or the treatment is for congenital learning or neurological disability/disorder; or the treatment is for communication training, educational training or vocational training. Personal Comfort Items - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies. Private Room - Private room, except as specified as Covered Services. Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under Covered Services. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw). Corrective eye surgery; Reversal of voluntary sterilization; Oral surgery that is dental in nature; Sexual Modification/Dysfunction Treatments - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).	Physician medical and surgical services while in an inpatient facility.	No

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19	**Bariatric Surgery**	Not Covered	Bariatric Surgery						Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under Covered Services. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e. g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).		
20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery						Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by BCBSHP, is not covered.		
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	30	Days per year			Benefits will not be provided when: A Member reaches the maximum level of recovery possible and no longer requires other than routine care; Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service; Care is for chronic brain syndromes for which no specific medical conditions exist that require care in a Skilled Nursing Facility; A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care; The care rendered is for other than Skilled Convalescent 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

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24	**Mental/ Behavioral Health Outpatient Services**	Covered	Mental/ Behavioral Health Outpatient Services	No					Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Contract provides for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered. - Self-Help - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing. - Sexual Modification/Dysfunction Treatments - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No

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25	**Mental/ Behavioral Health Inpatient Services**	Covered	Mental/ Behavioral Health Inpatient Services	No					Inpatient Mental Health - Inpatient Hospital care for mental health conditions when the stay is: determined to be court-ordered, custodial, or solely for the purpose of environmental control; rendered in a home, halfway house, school, or domiciliary institution; associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work situations. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Contract provides for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered. - Self-Help - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing. - Sexual Modification/Dysfunction Treatments - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No

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26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	No						Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No					Inpatient residential treatment centers	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No
28	**Generic Drugs**	Covered	Generic Prescription Drugs	No					Any services or supplies for the treatment of obesity, including but not limited to, Prescription Drugs, Nutritional supplements; Services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition; Food supplements; Appetite suppressants, and supplies of a similar nature. Smoking cessation products. Over the counter items. Cosmetic drugs. Prescriptions or medications related to hair growth.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs.	No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Prescription Drugs	No					Any services or supplies for the treatment of obesity, including but not limited to, Prescription Drugs, Nutritional supplements; Services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition; Food supplements; Appetite suppressants, and supplies of a similar nature. Smoking cessation products. Over the counter items. Cosmetic drugs. Prescriptions or medications related to hair growth.		No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Prescription Drugs	No					Any services or supplies for the treatment of obesity, including but not limited to, Prescription Drugs, Nutritional supplements; Services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition; Food supplements; Appetite suppressants, and supplies of a similar nature. Smoking cessation products. Over the counter items. Cosmetic drugs. Prescriptions or medications related to hair growth.		No

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31	**Specialty Drugs**	Covered	Specialty Prescription Drugs	No					Any services or supplies for the treatment of obesity, including but not limited to, Prescription Drugs, Nutritional supplements; Services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition; Food supplements; Appetite suppressants, and supplies of a similar nature. Smoking cessation products. Over the counter items. Cosmetic drugs. Prescriptions or medications related to hair growth.		No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	20	Visits per year			Hypnotherapy; Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetics therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide. Self-Help - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. Benefit limits are shared between rehabilitation and habilitation services. 20 visit limit for Physical Therapy and Occupational Therapy combined; Separate 20 visit limit for Speech Therapy; Separate 20 visit limit for Respiratory Therapy.	No
33	**Habilitation Services**	Covered	Habilitation Services	No					Hypnotherapy; Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide. Self-Help - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.	Includes physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between rehabilitation and habilitation services. 20 visit limit for Physical Therapy and Occupational Therapy combined; Separate 20 visit limit for Speech Therapy.	No

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34	**Chiropractic Care**	Covered	Spinal manipulation and manual medical intervention services	Yes	20	Visits per year				Correction of subluxations in the body to remove nerve interference or its effects. Interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.	No
35	**Durable Medical Equipment**	Covered	Medical Equipment and Supplies	No					The following items related to Durable Medical Equipment are specifically excluded: Air conditioners, humidifiers, dehumidifiers, or purifiers; Arch supports and orthopedic or corrective shoes; Heating pads, hot water bottles, home enema equipment, or rubber gloves; Sterile water; Deluxe equipment or premium services, such as motor driven chairs or beds, when standard equipment is adequate; Rental or purchase of equipment if you are in a facility which provides such equipment; Electric stair chairs or elevator chairs; Physical fitness, exercise, or ultraviolet/tanning equipment; Residential structural modification to facilitate the use of equipment; Other items of equipment which BCBSHP feels do not meet the listed criteria. Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace). Non-covered supplies are inclusive of but not limited to Band-Aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.	Durable medical equipment, medical devices and supplies, prosthetics and appliances.	No
36	**Hearing Aids**	Not Covered	Hearing Aids						Excludes Hearing Services - Hearing aids, hearing devices and related or routine examinations and services.		
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Tests	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	Advanced Diagnostic Imaging Services	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/Screenings and Immunizations	No						Preventive care that meets the recommendations described in the ACA for plans effective after 9/23/2010 but prior to 8/1/2012.	No
40	**Routine Foot Care**	Not Covered	Routine Foot Care						Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.		
41	**Acupuncture**	Not Covered	Acupuncture						Acupuncture and acupuncture therapy.		
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs						Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under Covered Services. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).		
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No

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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			Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

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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					Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections		No
6	**Other**	Covered	Injectable drugs and other drugs administered in a provider's office or other outpatient setting	No							No
7	**Other**	Covered	Vision Correction After Surgery or Accident	No						Prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury.	No
8	**Other**	Covered	Medical supplies, equipment, and education for diabetes care for all diabetics	No						Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the Physician.	No

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9	**Other**	Covered	Dental Services for Accidental Injury and Other Related Medical Services	No					Treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage. Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.	Dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. - the cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth; - the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face; - dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; - dental services to prepare the mouth for radiation therapy to treat head and neck cancer; and - covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.	No

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10	**Other**	Covered	Human Organ and Tissue Transplant Services	No					The following services and supplies rendered in connection with organ/tissue/bone marrow transplants are not covered: Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants; Transportation, travel or lodging expenses for non-donor family members; Donation related services or supplies associated with organ acquisition and procurement; Chemotherapy with autologous, allogeneic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; Any transplant not specifically listed as covered.	Includes medically necessary covered transplants 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.	No
11	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
12	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
13	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS