MAINE EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Anthem Health Plans of ME (Anthem BCBS)
Product Name	PPO
Plan Name	Blue Choice 20 with Rx 10 30 50 50
Supplemented Categories (Supplementary Plan Type)	Pediatric Oral (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					We do not provide benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as those devices remain in place. We do not provide benefits for services for sterilization or to reverse voluntarily induced sterility; orthagnatic surgery, except as specifically stated as a reconstructive surgery; refractive eye surgery; routine circumcisions; services related to any transsexual operation; TMJ services.		No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					We do not provide benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as those devices remain in place. We do not provide benefits for services for sterilization or to reverse voluntarily induced sterility; orthagnatic surgery, except as specifically stated as a reconstructive surgery; refractive eye surgery; routine circumcisions; services related to any transsexual operation; TMJ services.		No
6	**Hospice Services**	Covered	Hospice Services	No							No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency care When Traveling Outside the U.S.	No							No

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8	**Routine Dental Services (Adult)**	Not Covered	Dental Services						Benefits for Orthognathic Surgery, dentistry, dental surgery, dental implants or any other services.		
9	**Infertility Treatment**	Not Covered	Infertility Treatment						We do not provide Benefits for Diagnostic Services, procedures, treatment or other services related to Infertility. This exclusion also applies to drugs used to enhance fertility. We do not provide Benefits for costs associated with achieving pregnancy through surrogacy.		
10	**Long-Term/Custodial Nursing Home Care**	Not Covered	Long-Term/Custodial Nursing Home Care						We do not provide Benefits for services, supplies or charges for Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a Provider.		
11	**Private-Duty Nursing**	Not Covered	Private duty nursing services						Private duty nursing is excluded.		
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam	Yes	1	Exam(s) per 2 years				For Routine Exam beyond screening: limit 1 per year up to age 19; 1 every 2 years after age 1.	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	No					We do not provide Benefits for services, supplies or charges for Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a Provider.		No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/Ambulance	No							No

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17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No					No coverage for personal comfort items or private room charges; We do not provide benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as those devices remain in place. We do not provide benefits for services for sterilization or to reverse voluntarily induced sterility; orthagnatic surgery, except as specifically stated as a reconstructive surgery; refractive eye surgery; routine circumcisions; services related to any transsexual operation; TMJ services		No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No					We do not provide benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as those devices remain in place. We do not provide benefits for services for sterilization or to reverse voluntarily induced sterility; orthagnatic surgery, except as specifically stated as a reconstructive surgery; refractive eye surgery; routine circumcisions; services related to any transsexual operation; TMJ services		No
19	**Bariatric Surgery**	Covered	Bariatric Surgery	No						We provide limited Benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty.	No

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20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery						We do not provide Benefits for Cosmetic Services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. Examples of Cosmetic Services include, but are not limited to: surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).		
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	No					We do not provide Benefits for services, supplies or charges for Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a Provider.		No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No					We do not provide Benefits for any services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).	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	We do not provide Benefits for any services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). No coverage for routine circumcision services.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered. 48 hour minimum length of stay for vaginal delivery; 96 hour minimum length of stay for cesarean delivery.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	No					We do not provide Benefits for any of the following services or any services relating to: Smoking clinics; Sensitivity training; Encounter Groups; Educational programs except as indicated in the "Covered Services" section; Marriage, guidance, and career counseling; Codependency; Adult Children of Alcoholics (ACOA); Pain control (except as required by law for Hospice Care services); Activities whose primary purpose is recreational and socialization.	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No

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25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	No					We do not provide Benefits for any of the following services or any services relating to: Smoking clinics; Sensitivity training; Encounter Groups; Educational programs except as indicated in the "Covered Services" section; Marriage, guidance, and career counseling; Codependency; Adult Children of Alcoholics (ACOA); Pain control (except as required by law for Hospice Care services); Activities whose primary purpose is recreational and socialization.	Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	No						Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No

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27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No						Outpatient treatment for Mental Health Care; and Substance Abuse Care. Inpatient Hospital Services in a Hospital; or Residential Treatment Center Facility for Mental Health Care. Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital; or Substance Abuse Treatment Facility. Partial Hospitalization sessions; and Day/Night Visits.	No
28	**Generic Drugs**	Covered	Generic Prescription Drugs	No					Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides; Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form; Prescription Drugs for the treatment of weight reduction/anorectics; prescription drugs used to enhance fertility; food or dietary supplements.		No

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29	**Preferred Brand Drugs**	Covered	Preferred Brand Prescription Drugs	No					Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides; Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form; Prescription Drugs for the treatment of weight reduction/anorectics; prescription drugs used to enhance fertility; food or dietary supplements.		No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Prescription Drugs	No					Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides; Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form; Prescription Drugs for the treatment of weight reduction/anorectics; prescription drugs used to enhance fertility; food or dietary supplements.		No

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31	**Specialty Drugs**	Covered	Specialty Prescription Drugs	No					Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides; Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form; Prescription Drugs for the treatment of weight reduction/anorectics; prescription drugs used to enhance fertility; food or dietary supplements.		No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes		Other	Quantitative limit units apply, see EHB benchmark		We do not provide Benefits for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas. No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. We do not provide Benefits for maintenance services, treatments or therapy. We do not provide speech therapy benefits for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors. We do not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. 60 visit/year limit applies to physical, occupational and speech therapy combined. Benefit limits are shared between rehabilitation and habilitation services.	Yes

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33	**Habilitation Services**	Covered	Habilitation Services	Yes		Other	Quantitative limit units apply, see EHB benchmark		We do not provide Benefits for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas. No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. We do not provide Benefits for maintenance services, treatments or therapy. We do not provide speech therapy benefits for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors. We do not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. 60 visits/year limit applies to physical, occupational and speech therapy combined. Benefit limits are shared between rehabilitation and habilitation services.	No
34	**Chiropractic Care**	Covered	Spinal manipulation and manual medical intervention services	Yes	40	Visit(s) per year			No Benefits are provided for ancillary treatment such as massage therapy, heat, and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for Maintenance Therapy for chronic conditions.	Manipulation therapy for treating acute musculo-skeletal disorders.	No
35	**Durable Medical Equipment**	Covered	Medical Equipment and Supplies	No					Personal comfort items; Orthotic devices; prosthesis designed exclusively for athletic purposes; benefit does not apply to bandages and other disposable items that may be purchased without a prescription; food or dietary supplements; shoe inserts; Durable Medical Equipment does not include fixtures installed in your home or installed on your real estate; exercise equipment.	Benefits are available for durable medical equipment (DME), medical supplies and prosthetic devices.	No
36	**Hearing Aids**	Covered	Hearing Aids	Yes		Other	1 hearing aid per affected ear per 3 years.			Limit for 1 hearing aid per impaired ear every 36 months through age 18.	No

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37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Tests	No					We do not provide Benefits for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of the diagnosed condition.		No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Advanced Diagnostic Imaging Services	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/ Screenings and Immunizations	No						Preventive care that meets the recommendations described in the ACA for plans effective after 9/23/2010 but prior to 8/1/2012.	No
40	**Routine Foot Care**	Not Covered	Routine Foot Care						We do not provide Benefits for any services rendered as part of routine foot care or shoe inserts.		
41	**Acupuncture**	Not Covered	Acupuncture						No benefits for acupuncture.		
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs						Weight loss programs not approved by us, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate of Coverage.		
43	**Routine Eye Exam for Children**	Covered	Routine eye exam and refraction	Yes	1	Visit(s) per year				Pediatric Refraction: limit 1 visit per year.	No
44	**Eye Glasses for Children**	Covered	Eye Glasses for Children	Yes	1	Item(s) per 2 years	1 set of eyewear every 24 months				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Exam(s) per 6 months	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							No
6	**Other**	Covered	Injectable Drugs and Other Drugs Provided/Administered During an Office Visit	No							No
7	**Other**	Covered	Autism Services	No						We provide coverage for members who are five years of age or under for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.	Yes
8	**Other**	Covered	Autism Services - ABA	Yes	36000	Other	$36,000 per year			Applied Behavior Analysis is limited to $36,000 per year for children 5 years of age or under.	No
9	**Other**	Covered	Early Intervention Services	Yes	3200	Other	$3200 calendar year			Early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay.	No
10	**Other**	Covered	Vision Correction After Surgery or Accident	No						Benefits provided for the prescription, fitting, or purchase of glasses or contact lenses when medically necessary to treat accommodative strabismus, cataracts, or aphakia.	No
11	**Other**	Covered	Medical supplies, equipment, and education for diabetes care for all diabetics	No						Benefits for diabetes medication, equipment, and supplies which are medically appropriate and necessary. Benefits are limited to: insulin, insulin pumps, oral hypoglycemic agents, glucose monitors, test strips, syringes, lancets, and Outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by us.	No

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12	**Other**	Covered	Dental Services for Accidental Injury and Other Related Medical Services	No					Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.	We provide Benefits only for the following dental related services: Setting a jaw fracture; Removing a tumor (but not a root cyst); Removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting; Treatment within six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later. Benefits for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the Member is classified as vulnerable.· Repairing or replacing dental Prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.	No
13	**Other**	Covered	Human Organ and Tissue Transplants	No						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
14	**Outpatient Rehabilitation Services**	Covered	Cardiac Rehabilitation	Yes	24	Other	24 visits per cardiac episode				No
15	**Other**	Covered	Smoking Cessation	No						Benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. To be eligible for Benefits, these products and medications must be prescribed by your Physician. NRT products can include but are not limited to, nicotine patches, gum, or nasal spray. We provide Benefits for follow-up smoking cessation education and counseling. We provide Benefits for completing an approved smoking cessation program.	No
16	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
17	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
18	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS