NEW HAMPSHIRE EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from second largest small group product, Health Maintenance Organization
Issuer Name	Matthew Thornton Health Plan (Anthem BCBS)
Product Name	Matthew Thornton Blue
Plan Name	Matthew Thornton Blue Health Plan
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					Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		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.								
8	**Routine Dental Services (Adult)**	Not Covered	Dental Services						No Benefits are available for preventive Dental Services. X-rays of the teeth are not covered. Orthodontia, TMJ appliances, splints or guards, braces, false teeth and biofeedback training are not covered. No Benefits are available for treatment or evaluation of a periodontal disorder, disease or abscess. Osseous and flap procedures, scaling, root planning, prophylaxis and periodontal evaluations are not covered. No Benefits are available for treatment of cavities or care of the gums. No Benefits are available for restorative Dental Services, even if the underlying dental condition affects other health factors. No Benefits are available for noncovered dental procedures. Covered.		

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
9	**Infertility Treatment**	Not Covered	Infertility Treatment						No coverage for infertility treatments or ART procedures.	Benefits are available only to for diagnostic services to determine the cause of medically documented infertility.	
10	**Long-Term/Custodial Nursing Home Care**	Not Covered	Long-Term/Custodial Nursing Home Care						No Benefits are available for services, supplies or charges for Custodial Care. Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered.		
11	**Private-Duty Nursing**	Not Covered	Private duty nursing services						Benefits are not provided for private duty nurses.		
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam	Yes	1	Other	1 every 2 years			Routine eye exam and refraction.	No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Services in an Urgent Care Center or Facility	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	No					No Benefits are available for services, supplies or charges for Custodial Care.		No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/Ambulance	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
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No					No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Non covered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges. Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No					No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Non covered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges. Reversal of voluntary sterilization. Sclerotherapy for varicose veins and treatment of spider veins. Sex change treatment. Corrective eye surgery.		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
19	**Bariatric Surgery**	Covered	Bariatric Surgery	No					Surgery to treat the condition of obesity itself or morbid obesity itself is not covered.	Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity.	No
20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery						No benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical condition caused by or providing in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services.		
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	100	Days per year			No Benefits are available for services, supplies or charges for Custodial Care. No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Non covered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.		No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No					Costs associated with surrogate parenting or gestational carriers are not covered.		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
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Facility and Professional Services for Maternity Care	No				48	Costs associated with surrogate parenting or gestational carriers are not covered.	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

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
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	No					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	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

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	No					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	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

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					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	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

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
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No					No Benefits are available for the following: Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders. Duplication of services (the same services provided by more than one therapist during the same period of time). Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling. Services for nicotine withdrawal or nicotine dependence. Psychoanalysis. Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings. Missed appointments. Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider. Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition. Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.	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

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
28	**Generic Drugs**	Covered	Generic Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		No
31	**Specialty Drugs**	Covered	Specialty Prescription Drugs	No					Appetite suppressants, anorectics, or any drug used for the purpose of weight management. Cosmetic agents or medications used for cosmetic purposes. Nonlegend (over-the-counter) prescriptions. Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Drugs used as a part of sex change treatment.		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
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	20	Visits per year			Non covered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes affecting the voice. No Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except for “Early Intervention Services”. No Benefits are available for sport, recreational or occupational reasons. Physical therapy for TMJ disorders is not covered. No Benefits are available 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 available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.	Includes physical therapy, occupational therapy, speech therapy, respiratory therapy and cardiac rehabilitation. Separate 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation 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
33	**Habilitation Services**	Covered	Habilitation Services	Yes	20	Visits per year			Non covered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes affecting the voice. No Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except for “Early Intervention Services”. No Benefits are available for sport, recreational or occupational reasons. Physical therapy for TMJ disorders is not covered. No Benefits are available 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 available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.	Includes physical therapy, occupational therapy, speech therapy. Separate 20 visit/year limit applies to physical, occupational and speech therapy. Benefit limits are shared between rehabilitation and habilitation services.	No
34	**Chiropractic Care**	Covered	Spinal manipulation and manual medical intervention services	Yes	12	Visits per year			Wellness care is not covered.	Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment; and Medically Necessary diagnostic laboratory and x-ray tests.	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
35	**Durable Medical Equipment**	Covered	Medical Equipment and Supplies	No					No Benefits are available for: Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification; Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds; Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this subsection; Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, items for personal hygiene; Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans; Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems); Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device; Safety equipment, including, but not limited to: hats, belts, harnesses, glasses or restraints; Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system; Self-monitoring devices except as stated in 2 “Medical Supplies” (above), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment;	Benefits are available for durable medical equipment (DME), medical supplies and prosthetic devices.	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
									and Dentures, orthodontics, dental prosthesis and appliances. No Benefits are available for appliances used to treat temporomandibular joint (TMJ) disorders. Convenience Services are not covered, including but not limited to personal comfort items and any equipment, supply or device this is primarily for the convenience of a Member, the Member's family or a Designated Provider. Food and food supplements are not covered except as specified. Nutrition and/or dietary supplements are not covered. Home test kits are not covered.		
36	**Hearing Aids**	Covered	Hearing Aids	Yes	1	Other	1 per ear each time prescription changes		No Benefits are available for hearing aids for Members who are 19 years old or older.	Benefits are available for one hearing aid per ear each time a hearing aid prescription changes for Members who are 18 years old or younger.	No
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Tests	No					No Benefits are available for diagnostic x-rays in connection with research or study.		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						No Benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered.		

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
41	**Acupuncture**	Not Covered	Acupuncture						No Benefits are available for alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.		
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs								
43	**Routine Eye Exam for Children**	Covered	Routine eye exam and refraction	Yes	1	Visits per year				Routine eye exam and refraction. Supplemented using FEDVIP.	No
44	**Eye Glasses for Children**	Covered	Eye Glasses for Children	Yes	1	Other	1 pair of glasses (lenses and frames per year)			Frames and lenses or contacts. Supplemented using FEDVIP.	No
45	**Dental Check-Up for Children**	Covered	Routine Dental Services for Children	Yes	2	Visits per year				Limitations, including dollar limits, may apply. Supplemented using FEDVIP.	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	Bone Marrow Testing (HLA) for Donation	No							No
2	**Other**	Covered	Diabetes Treatment	No							No
3	**Other**	Covered	Chiropractic Care	No							No
4	**Other**	Covered	Qualified Clinical Trials	No							No
5	**Other**	Covered	Contraceptive Services	No							No
6	**Other**	Covered	Dental Procedures: Performed At Dental Office	No							No
7	**Other**	Covered	Dental Procedures: Medical or Hospital Group	No							No
8	**Other**	Covered	Diabetes Services and Supplies	No							No
9	**Other**	Covered	Early Intervention Therapy Services	No							No
10	**Other**	Covered	Hearing Aids	No							No
11	**Other**	Covered	Mammography & for Testing for Occult Breast Cancer	No							No
12	**Other**	Covered	Mental Health - Biologically Based Mental Illnesses	No							No
13	**Other**	Covered	Mental Health - Mental or Nervous Conditions and Treatment for Chemical Dependency Required	No							No
14	**Other**	Covered	Mental Health - Treatment Of Pervasive Developmental Disorder Or Autism	No							No
15	**Other**	Covered	Nonprescription Enteral Formulas	No							No
16	**Other**	Covered	Obesity & Morbid Obesity / Bariatric Surgery	No							No
17	**Other**	Covered	Pregnancy, Delivery and Postpartum	No							No
18	**Other**	Covered	Prescription Contraceptives	No							No
19	**Other**	Covered	Prostheses - Artificial Limb	No							No
20	**Other**	Covered	Prostheses - Scalp Hair Prostheses	No							No
21	**Other**	Covered	Reconstruction Surgery as a Result of Mastectomy	No							No
22	**Other**	Covered	Telemedicine Act	No							No
23	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
24	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
25	**Other**	Covered	Orthodontia – Child	No						Limitations, including dollar limits, may apply.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS