

Essential Health Benefits Guidance

Important Information

NOTE: This guidance was developed as a resource for carriers for product design purposes and to promote compliance with the essential health benefits requirements. This guidance is offered to assist carriers but may be subject to change; accordingly, it is not binding on the Bureau or the federal Department of Health and Human Services. This guidance should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state and federal insurance laws and associated rules and regulations. It is the responsibility of the carriers to verify that their products comply with all relevant statutory and regulatory requirements.

The Patient Protection and Affordable Care Act (“ACA”) requires that all non-grandfathered individual and small group health insurance plans sold in the Commonwealth of Virginia (“Commonwealth”), beginning January 1, 2014, cover certain delineated essential health benefits (“EHBs”). In a 2011 bulletin and a final rule released in February of 2013, the United States Department of Health and Human Services (“HHS”) provided states with the option to choose a plan from a range of existing health insurance plans to serve as an EHB benchmark plan, which ultimately defines the standard set of benefits that must be covered by plans in the individual and small employer group markets in each state.

The EHB benchmark plan chosen by the Commonwealth is *Anthem PPO KeyCare 30*, the small group health plan with the largest enrollment in the state and the Medicaid CHIP (*SMILES*) plan for pediatric dental. The default plan for pediatric vision is the Federal Employee Plan (FEP) *Blue Vision* plan. Rules recently released by HHS indicate that Virginia’s pediatric dental benchmark plan is the federal employee plan (FEDVIP); however, the State Corporation Commission’s Bureau of Insurance (“Bureau”) understands that this was an error and that the “Summary of EHB Benefits and Limits” template available on the Center for Consumer Information and Insurance Oversight (CCIIO) website has been corrected.

The Bureau developed this guidance based on the benefits included in the above-mentioned benchmark plans. This guidance identifies the ten required EHB categories as well as the varying benefits and services that fall within them. These benefits and services must be specifically addressed in all non-grandfathered individual and small group health plans sold in the Commonwealth on or after January 1, 2014. Because EHBs are based on 2012 plan designs, some

policy provisions of the EHB-benchmark plan will need to be redesigned to comply with new requirements and limitations for plan years beginning on January 1, 2014.

Notice: This document is prepared to provide guidance as it relates to Virginia legislation that requires that policies to be sold in the individual and small group markets in Virginia provide coverage that includes essential health benefits.

Essential Health Benefits Benchmark Plan Anthem PPO KeyCare 30; Medicaid CHIP (Smiles) – pediatric dental; FEDVIP 2012 BlueVision High Option – pediatric vision			
Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
I. Ambulatory Patient Services			
A. Primary Care Office Visit – Injury/ Illness	Code of Virginia § 38.2-3443	Schedule of Benefits (SOB) pg. 1; page 17	Including doctor visits in the home
B. Specialist Office Visit	38.2-3443	SOB pg. 1; page 17	
C. Other Practitioner Office Visit (Nurse, Physician Assistant)		Pages 77-78	Includes Retail Health Clinics (walk-ins)
D. Urgent Care Visit		Page 17	
E. Ambulatory Surgery Center		SOB pg. 3; page 30	
1. Facility Fee		SOB pg. 3; page 30	Includes coverage for blood and blood products.
2. Outpatient Surgery Physician/Surgical Services		SOB pg. 3; page 30	
3. Medical and Surgical Supplies		Page 22	Includes hypodermic needles and syringes
4. Anesthesia		SOB pg. 2; Pages 15, 20	

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
F. Outpatient Hospital Facility		SOB pg. 2; page 19	
1. Facility Fee		SOB pg. 2; page 19	Includes coverage for blood and blood products.
2. Professional Services at Hospital Outpatient Facility		SOB pg. 2; page 19	
3. Medical and Surgical Supplies		Page 22	
4. Anesthesia		SOB pg. 2; Pages 15, 20	
G. Radiation therapy		SOB pg. 3; page 31	
1. Radiation Administration		SOB pg. 3; page 31	
H. Respiratory therapy		SOB pg. 3; page 32	
I. Non-Emergency Care when Traveling Outside United States		Page 8	Included in template, but not an EHB.
J. Basic Adult Dental Care		SOB pg. 1; pages 15, 30, 34-35	Only covered as medically necessary if resulted from accidental injury. Repair of dental appliances damaged in accidental injury to jaw, mouth, or face. Dental services to prepare the mouth for radiation therapy to treat head and neck cancer.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
K. Major Adult Dental Care		SOB pg. 1; pages 15, 30, 34-35	same as above
L. Adult Orthodontia		SOB pg. 1; pages 15, 30 34-35	same as above
M. Non-routine Adult Eye Care		SOB pg. 3; pages 32, 41	Vision corrected following surgery or accident. Glasses & contacts covered in such instances.
N. Infusion Services - Inpatient, outpatient and home settings.		SOB pg. 2; page 20	Infusion of therapeutic agents, medication, and nutrients; infusion of enteral nutrition into the gastrointestinal tract; infusion of prescription medications.
O. Chemotherapy	38.2-3407.18	SOB pg. 3; page 31	
P. Outpatient End Stage Renal Disease Treatment (Dialysis)		SOB pg. 1; page 17	Includes hemodialysis and peritoneal dialysis.
Q. Diagnostic Colonoscopy	38.2-3418.7:1	SOB pg. 1; page 16	
R. Allergy Testing and Treatment		Pages 17, 29	
S. In-home Hospice	38.2-3418.11	SOB pg. 2; pages 18-19	
T. Bones/Joints (TMJ diagnostic and Surgical Procedures)	38.2-3418.2	Pages 30, 35	Does not cover appliances for temporomandibular joint pain dysfunction.
U. Equipment /Supplies/ Therapy/ Training and Education for treatment of Lymphedema	38.2-3418.14	Pages 30, 31	

Essential Health Benefits Benchmark Plan Anthem PPO KeyCare 30; Medicaid CHIP (Smiles) – pediatric dental; FEDVIP 2012 BlueVision High Option – pediatric vision			
Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
V. Blood & Blood Services: Hemophilia & Congenital Bleeding Disorders	38.2-3418.3		
W. Clinical Trials for Cancer	38.2-3418.8	Pages 35, 81	
X. Approved Clinical Trials for Life-threatening Diseases or Conditions	PHSA § 2709; 38.2-3453		
Y. Telemedicine	38.2-3418.16	Pages 17, 40, 79	
Z. Sleep Testing and Treatment			
AA. Vision Correction after Surgery or Accident		Page 32	Covers prescription glasses or contact lenses required as a result of surgery or for treatment of accidental injury. Includes cost of materials and fitting, exams, and replacement of eyeglasses or contact lenses if related to the surgery or injury. Eyeglass or contact lens purchase and fitting are covered under this benefit if: (i) prescribed to replace the human lens lost due to surgery or injury; (ii) “pinhole” glasses are prescribed after surgery for a detached retina; or (iii) lenses are prescribed instead of surgery due to: (a) contact lenses used for treatment of infantile glaucoma; (b) corneal or sclera lenses prescribed in connection with keratoconus; (c) scleral lenses prescribed to retain moisture when normal tearing is not possible or is inadequate; or (d) corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.

Essential Health Benefits Benchmark Plan Anthem PPO KeyCare 30; Medicaid CHIP (Smiles) – pediatric dental; FEDVIP 2012 BlueVision High Option – pediatric vision			
Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
AB. Infertility		Benchmark Template pg. 3	Covers services to diagnose and treat conditions resulting in infertility.
II. Emergency Services	PHSA § 2719A and 38.2-3445		
A. Emergency Room Professional Services		SOB pg. 1; pages 17-18	
B. Emergency Room Facility Services		SOB pg. 1; page 18	
C. Emergency Transportation/Ambulance (Vehicle)		SOB pg. 1; page 15	
1. Emergency Transportation (Air)		SOB pg. 1; page 15	
D. Out-of-Network Emergency Services		SOB pg. 1; pages 10, 15, 74-75	Visits to out-of-network emergency rooms for emergency services (as defined in the plan document) and supplies are covered at in-network levels, and in-network cost shares apply. Facility and provider may balance bill for amounts in excess of the maximum allowed amount (as defined in the plan document).
E. Emergency Care Outside United States		Page 8	In- and Out-of-network services available; In-network benefits apply, but patient is responsible for difference of billed amount and maximum allowed amount. Plan will only pay non-participating provider the amount that would have been paid a participating provider for the same service.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
III. Hospitalization			
A. Inpatient Hospital Services		SOB pg 2; pages 16, 19-20, 22, 23-24	Covered for injury, illness, or pregnancy - to include drugs, injectable drugs, blood, oxygen and nuclear medicine.
1. Room and Board		Page 19	
2. Professional Inpatient Services		SOB pg. 2; page 19	Includes Physician, Surgical and General Nursing Services.
3. Anesthesia		SOB pg. 2; Pages 15, 20	
4. Anesthesia and Hospital Charges for Dental Procedures for Children Under Age 5, or Persons who are severely disabled or have a medical condition	38.2-3418.12	SOB pg. 1; page 15	
5. Medical and Surgical Supplies		Page 22	Includes hypodermic needles and syringes.
B. Hospice	38.2-3418.11	SOB pg. 2; page 18	
C. Skilled Nursing Facility		SOB pg. 2; pages 29, 40	Includes room and board; rehabilitative services; and drugs, biologicals, and supplies. Minimum Requirement: 100 days per stay
D. Transplant Surgery – Recipient Charges		Pages 30-31, 38; Benchmark Template pg. 13	Organ and tissue transplants and transfusions; includes autologous bone marrow transplants for breast cancer. Also covers necessary acquisition procedures, harvest and storage, and preparatory myeloablative therapy.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
1. Transplant Surgery – Donor Charges		Pages 30-31; Benchmark Template pg. 13	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 benefits. Costs related specifically to transportation and lodging are covered.
E. Surgery to Correct Congenital Anomalies	38.2-3411	Pages 32, 34	Covered to correct functional impairment, newborn congenital abnormalities.
F. Oral and Maxillofacial Surgery	38.2-3418.2	Page 30	Covered for maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy related to tooth extraction; orthognathic surgery required to attain functional capacity; surgical services on the hard or soft tissue of the mouth for purposes not related to treat or help teeth and supporting structures; and treatment of cleft lip, cleft palate, or ectodermal dysplasia.
G. Reconstructive Breast Surgery following a Mastectomy	38.2-3418.4; 38.2-3418.6	SOB pg. 3; pages 11, 30	Done at same time of mastectomy or following a mastectomy to establish symmetry. Hosp stays must be no less than 48 hours for radical and no less than 24 hours for total or partial mastectomy with lymph node dissection.
H. Postmastectomy/Lymph Node Dissection Inpatient Care	38.2-3418.6	Page 11	Hospital stays must be no less than 24 hours for total or partial mastectomy w/ lymph node dissection.
I. Minimum Hospital Stay for Hysterectomy	38.2-3418.9	Page 11	No less than 23 hours for laparoscopic hysterectomy and 48 hours for a vaginal hysterectomy.
J. Bones and Joints (TMJ Surgical Procedures)	38.2-3418.2	Page 30	Deemed medically necessary to attain functional capacity of the affected part.
K. Hemophilia & Congenital Bleeding Disorders	38.2-3418.3		

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
L. Diagnostic Genetic Testing and Counseling	PHSA § 2705	Page 21 (fetal screenings)	BRCA and fetal screenings are covered. Diagnostic genetic testing and counseling shall not be excluded, except when not medically necessary in accordance with medical policy.
M. Clinical Trials for Cancer	38.2-3418.8 and PHSA § 2709	Pages 35,81	Must include coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.
N. Approved Clinical Trials for Life-threatening Diseases or Conditions	PHSA § 2709; 38.2-3453		
IV. Maternity and Newborn Care	PHSA §2725		All services described in this section are covered for the subscriber or a covered dependent who becomes pregnant.
A. Pregnancy Testing		Page 20	
B. Services for interruption of pregnancy	PPACA §1303; 38.2-3451	Page 20	May be offered outside of an exchange, but is not required for EHB. “No qualified health insurance plan that is sold or offered for sale through an exchange established or operating in the Commonwealth shall provide coverage for abortions, regardless of whether such coverage is provided through the plan or is offered as a separate optional rider thereto, provided that such limitation shall not apply to an abortion performed (i) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (ii) when the pregnancy is the result of an alleged act of rape or incest.”

Essential Health Benefits Benchmark Plan Anthem PPO KeyCare 30; Medicaid CHIP (Smiles) – pediatric dental; FEDVIP 2012 BlueVision High Option – pediatric vision			
Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
C. Prenatal and Postnatal Care	38.2-3442; 38.2-3407.16	SOB pg. 2; pages 20-21	Covered for subscriber and dependent. Covers maternity care, and maternity-related checkups. Prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary.
D. Prenatal Screenings	38.2-3442	SOB pg. 2; pages 20-21	Covers fetal screenings for genetic and/or chromosomal status of fetus. Also, anatomical, biochemical or biophysical tests to better define likelihood of genetic and/or chromosomal anomalies. All as recommended for Grades A and B of US Preventive Services Task Force.
E. Delivery and all Inpatient Services for Maternity Care	38.2-3414.1; 38.2-3407.16	SOB pg. 2; pages 20-21	Use of delivery room and care; anesthesia services. Minimum Requirement: Must conform with guidelines for perinatal care
1. Hospital Delivery Facility Fee		SOB pg. 2; pages 20-21	
2. Physician Services for Delivery		SOB pg. 2; pages 20-21	
F. Delivery by Midwife		SOB pg. 2; pages 20-21	
G. Postnatal Care Services (Baby)	38.2-3411; 38.2-3442	SOB pg. 2; pages 20-21	Covers Hemoglobinopathies screening; Gonorrhea prophylactic medication Hypothyroidism screening; PKU screening; Rh incompatibility screening - Covered US Preventive Services Task Force Grades A and B recommendations. Must include dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
H. Postpartum Care Services (Mother)	38.2-3414.1	SOB pg. 2; pages 20-21	
I. Routine Newborn Nursery & Care	38.2-3411, 38.2-3442	SOB pg. 2; page 20	Hospital services for routine nursery care during mother's normal hospital stay. Initial examination of newborn; circumcision of covered male dependent.
J. Breastfeeding/Lactation Counseling and Equipment	38.2-3442	Page 33	US Preventive Services Task Force Grade B recommendation
V. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	PHSA § 2726		Shall not apply day/visit limitations for treatment not also applied under the Medical/Surgical benefit.
A. Mental Health/Behavioral Health Outpatient Services		SOB pg. 2; pages 22, 37	Visits for medication checks are covered. Includes diagnosis & treatment of psychiatric conditions, including psychotherapy, group psychotherapy, & psychological testing.
1. Office based		SOB pg. 2; pages 22, 37	
2. Outpatient Facility		SOB pg. 2; pages 22, 37	
3. Outpatient Professional Services		SOB pg. 2; pages 22, 37	
B. Mental Health/Behavioral Health Inpatient Services		SOB pg. 2; pages 22, 37	Includes individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with patient's diagnosis and treatment, and convulsive therapy treatment.
1. Inpatient Facility		SOB pg. 2; pages 22, 37	

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
2. Inpatient Professional Services		SOB pg. 2; pages 22, 37	
C. Substance Use Disorder Outpatient Services		Pages 22-23, 37	Visits for medication checks are covered.
1. Office based		Pages 22-23, 37	
2. Outpatient Facility		Pages 22-23, 37	
3. Outpatient Professional Services		Pages 22-23, 37	
D. Substance Use Disorder Inpatient Services/ Detoxification and Rehabilitation		Pages 22-23, 37	Includes substance abuse treatment facility. Includes individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with patient's diagnosis and treatment, and convulsive therapy treatment.
1. Inpatient Facility		Pages 22-23, 37	
2. Inpatient Professional Services		Pages 22-23, 37	
E. Partial Day/Intensive Outpatient Services		SOB pg. 2; page 23	Partial Hospitalization is defined in 38.2-3412.1.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
F. Residential Treatment Facilities / Centers (RTFs or RTCs)		Page 39	Coverage for inpatient services for substance abuse, eating disorders and the like must be provided in a hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care. Care from a residential treatment facility (RTF) or other non-skilled, sub-acute setting may be excluded if the services are merely custodial, residential or domiciliary in nature.
VI. Prescription Drugs	PPACA § 1302 PHSA § 2707		May carry an out-of-pocket maximum separate from the out-of-pocket maximum for other medical services but the combined max for essential health benefits must be within required limits. Must cover the same number of drugs as the benchmark in each class or at least one in each class, whichever is greater.
A. Generic Drugs, including Specialty and Biological Drugs		SOB pg. 4; pages 23-28	
B. Preferred Brand Drugs, including Specialty and Biological Drugs		SOB pg. 4; pages 23-28	
C. Non-Preferred Brand Drugs, including Specialty and Biological Drugs		SOB pg. 4; pages 23-28	
D. Prescription Contraceptives	38.2-3407.5:1	Page 23	May be excluded for certain exempt religious groups. Covers FDA-approved contraceptive drugs and devices, and office visits associated with contraceptive management. Minimum requirement: No cost sharing if covered.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
E. Off-label drugs and cancer drugs	38.2-3407.5; 38.2-3407.6:1	Page 80	
F. Medical Food supplements		Pages 22, 76	Covered only for nutrition infusion in the home and special medical formulas which are the primary source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality, or severe protein or soy allergies.
G. Injectable drugs and drugs administered in an outpatient setting		SOB pg. 2; pages 25, 27, 29; Benchmark Template pg. 11	
VII. Rehabilitative and Habilitative Services and Devices			Habilitative Services include coverage for health care services that help a person keep, learn, or improve skills and functioning for daily living. Rehabilitative services include coverage for therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.
A. Inpatient Rehabilitative/Habilitative Services and Devices		SOB pg. 3; pages 19, 31	
1. Inpatient Rehabilitation Facility		SOB pg. 3; pages 19, 31	

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
2. Inpatient Rehabilitation Professional Services		SOB pg. 3; pages 19, 31	
B. Outpatient Rehabilitation Services		SOB pg. 3; page 31	
1. Outpatient Rehabilitation Facility		SOB pg. 3; page 31	
2. Outpatient Rehabilitation Professional Services		SOB pg. 3; page 31	
C. Physical/Occupational Therapy		SOB pg. 3; page 31	Minimum Requirement: 30 visits per calendar year combined for rehabilitative or habilitative services.
D. Speech Therapy		SOB pg. 3; page 32	Minimum Requirement: 30 visits per calendar year combined for rehabilitative or habilitative services.
E. Other Rehabilitative/Habilitative Therapies			
1. Respiratory Therapy		SOB pg. 3; page 32	
2. Cardiac Rehabilitation		SOB pg. 3; page 31	
3. Early Intervention Services	38.2-3418.5	SOB pg. 1; pages 17-18	Must include coverage as specified in Section 38.2-3418.5, except the dollar limit does not apply. No therapy visit maximum applies to occupational, physical, or speech therapy services received under this benefit.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
4. Private-Duty Nursing		SOB pg. 2; pages 18, 39	Medically skilled services of a licensed RN or LPN in home. Minimum Requirement: Actuarial equivalent of \$500 per calendar year, or 16 hours per calendar year
5. Home Health Care Services		SOB pg. 2; pages 18, 36, 76	Intermittent care provided in home. Includes: visits by licensed health care professional (includes nurse, therapist, or home health aide) and physical, speech, & occupational therapy (services provided as part of home care are not subject to separate visit limits for therapy services). Minimum Requirement: 100 visits per calendar year
6. Chiropractic Care - Spinal manipulations and other manual medical interventions	38.2-3408	SOB pg. 3; pages 30, 40	Does not cover spinal or other manual medical interventions for an illness or injury other than musculoskeletal. Minimum Requirement: 30 visits per calendar year
F. Rehabilitative/Habilitative Devices			
1. Adult Corrective Lenses		Pages 28, 32, 87	Covered only when prescribed as a result of surgery or for the treatment of accidental injury.
2. Orthotics		SOB pg. 2; pages 21-22, 35-36, 37	Orthotics, other than foot orthotics, are covered, including cost of fitting, adjustment, and repair.
3. Prosthetics	38.2-3418.15	SOB pg. 2; pages 21-22; Benchmark Template pg. 9	Covers prosthetic devices and components; cochlear implants; orthopedic braces; leg braces, including attached or built-up shoes attached to a leg brace; molded, therapeutic shoes for diabetics with peripheral vascular disease; arm braces, back braces and neck braces; head

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
			halters; catheters and related supplies; and splints.
4. Durable Medical Equipment		SOB pg. 2; pages 21, 36-37, 76	Rental (or purchase if less expensive) covered when prescribed by doctor. Also, maintenance & necessary repairs covered except if damage is due to neglect. Covered equip includes: nebulizers, hosp-type beds, wheelchairs, traction equip, walkers & crutches.
5. Supplies	38.2-3418.10	SOB pgs. 2, 4; pages 16, 17, 18, 19, 22, 23, 29	Medical supplies, including those needed for diabetes care, as prescribed by a doctor.
VIII. Laboratory Services			
A. Diagnostic Tests			
1. Radiology		SOB pgs. 1, 2; pages 16-17	Includes x-rays, mammograms, ultrasound or nuclear medicine.
2. Lab and Pathology Services		SOB pgs. 1, 2; pages 16-17	
3. EKGs, EEGs		SOB pgs. 1, 2; pages 16-17	
4. Advanced Imaging		SOB pgs. 1, 2; pages 16-17	Includes MRA, MRI, MRS, CTA, PET scans, CT scans, SPECT scans, and nuclear cardiology.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
5. Professional Services for test interpretation, x-ray reading, lab interpretation, and scan reading		SOB pgs. 1, 2; pages 16-17	
IX. Preventive and Wellness Services and Chronic Disease Management	PHSA §2713		
A. Preventive Care/ Screening/ Immunization	38.2-3442; 38.2-3411.1	SOB pg. 3; pages 32-33	
1. Adult Routine Physical Exams or Immunizations		SOB pg. 3; pages 32-33	Covered at 100% under preventive care guidelines.
2. Adult Routine Eye Exam and refraction		SOB pg. 4; page 28; Benchmark Template pg. 4	1 routine eye exam per calendar year (optional).
B. Chronic Disease Care Management			
1. Diabetes Care Management	38.2-3418.10	SOB pg. 1; pages 16, 35	Must include medical supplies, equipment, education, and routine diabetic foot care - treatment of corns, calluses, and care of toenails.
2. Home Dialysis Equipment and Supplies		SOB pg. 1; page 16	
3. Dialysis Treatments in Facility or Doctor's Office		SOB pg. 1; page 16	
4. Oxygen		Page 22	Includes oxygen and equipment for its administration.

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
5. Medical Formulas		Page 22	Special medical formulas that are the primary source of nutrition for persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.
C. Wellness Services	38.2-3442	SOB pg. 3; pages 32-33	All US Preventive Services for A and B under Task Force. Minimum Requirement: No cost sharing
1. PSA Testing & Digital Exams	38.2-3418.7	SOB pg. 3; pages 32-33	Must cover preventive screening by means stated in mandate provisions of Section 38.2-3418.7.
2. Routine Mammography Screening	38.2-3418.1	SOB pg. 3; pages 32-33	Must cover preventive screening by means stated in mandate provisions of Section 38.2-3418.1.
3. HPV/Cervical Cancer Screening	38.2-3418.1:2	SOB pg. 3; pages 32-33	Must cover preventive screening by means stated in mandate provisions of Section 38.2-3418.1:2.
4. Colorectal Cancer Screening	38.2-3418.7:1	SOB pg. 3; pages 32-33	Must cover preventive screening by means stated in mandate provisions of Section 38.2-3418.7:1.
5. Nutritional Counseling	38.2-3442, 38.2-3418.10	SOB pg. 3; pages 19, 33-34, 38	Covered when received as part of a covered wellness service screening, diabetes education, and for hospice with respect to person's care and death. Also covered in Preventive Care Guidelines in certain situations.
6. Smoking and Tobacco Cessation Counseling	38.2-3442	Pages 38, 40	
7. Domestic Violence Screening and Counseling			
X. Pediatric Services, including Oral and Vision Care			At least up to age 19

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Category	Federal & State Law/ Authority	Benchmark Reference	Comments:
A. Well-Baby and Well-Child Care, including Immunizations	38.2-3411.3; 38.2-3442; and 38.2-3411.1	SOB pg. 3; pages 32-33	Must at least include the minimum provision of Sections 38.2-3411.3 and 38.2-3442. Covered at 100% under preventive care guidelines.
B. Routine Hearing Screening	38.2-3411.4; 38.2-3442	SOB pg. 3; pages 32-33	Must at least include the minimum provision of Sections 38.2-3411.4 and 38.2-3442. Covered at 100% as provided for in guidelines supported by the Health Resources and Services Administration.
C. Routine Eye Exam	FEDVIP 2012 BlueVision High Option	SOB pg. 4; pages 28-41	Minimum Requirement: one routine eye exam per calendar year.
D. Eye Glasses and Contact Lenses	FEDVIP 2012 BlueVision High Option		Minimum Requirement: One pair of standard eyeglass lenses or contact lenses every year; one frame every year.
E. Other Eye Care	FEDVIP 2012 BlueVision High Option		In accordance with FEDVIP High Option minimum requirements.
F. Dental Care, including Preventive and Diagnostic Dental Care, Basic Dental Care, Major Dental Care, and Orthodontia	Medicaid CHIP (Smiles); 38.2-3411 B	SOB pg. 1; pages 15, 34	Covered services include: dental checkups twice/year; cleaning and fluoride treatments twice/year; sealants; space maintainers; extractions; root canal treatment; crowns; x-rays; and other medically necessary dental services, to include orthodontia up to age 19.

Excluded Services	Related State law(s) and/or Applicable Mandate for partial services	Benchmark Reference
The following services are specifically excluded in the benchmark plan, are not required, and may be excluded		

Applied Behavioral Analysis		
Acupuncture	38.2-3408 A	Page 34
Birth Center		
Biofeedback Therapy, neurofeedback, and related testing		Pages 34, 40
Cosmetic Surgery or procedures , including related procedures and complications that result from such surgeries or procedures.	38.2-3411 B	Page 34
Custodial or residential care in skilled nursing facility or other facility is not covered except for hospice care		Pages 29, 36, 39
Adult Dental Services , including: treatment of natural teeth due to diseases; routine dental care; supplies or dental x-rays; extraction of erupted or impacted wisdom teeth; oral surgeries or periodontal work on the hard and/or soft tissue supporting the teeth to help support structures; periodontal, prosthodontal or orthodontic care.		Pages 34-35
Donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate blood-related family members.		Page 35; Benchmark Template pg. 13

Excluded Services	Related State law(s) and/or Applicable Mandate for partial services	Benchmark Reference
The following services are specifically excluded in the benchmark plan, are not required, and may be excluded		

DME , appliances, devices, and medical supplies that have both a non-therapeutic and therapeutic use, including exercise equip; air conditioners, purifiers, and humidifiers; hypoallergenic bed linens; whirlpool baths; handrails, ramps, elevators, & stair glides; telephones; adjustments made to vehicle; foot orthotics; changes made to home or business; or repair or replacement of equipment lost or damaged through neglect.		Pages 36-37
Durable Medical Equipment not appropriate for use in the home.		Page 37
Drugs for Certain Clinical Trials	38.2-3418.8 and 38.2-3453	Page 81
Educational, vocational, or self-management training services or supplies, except as otherwise specifically covered or when received as part of a covered wellness visit or screening.	38.2-3418.10	Page 35
Experimental/investigational procedures , and their complications, except for clinical trial costs required to be covered under law.	38.2-3418.8 and 38.2-3453	Page 35
The following family planning services are excluded: artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception; drugs in connection with such procedures or to treat infertility; surrogate pregnancy expenses when the person is not covered under your plan; services to reverse voluntarily induced sterility; paternity testing.		Page 35

Excluded Services	Related State law(s) and/or Applicable Mandate for partial services	Benchmark Reference
The following services are specifically excluded in the benchmark plan, are not required, and may be excluded		
Foot care (palliative or cosmetic), including flat foot conditions; support devices, arch supports, foot inserts, orthopedic and corrective shoes not part of a leg brace and fitting, castings and other services related to devices of the feet; foot orthotics; subluxations of the foot; corns, calluses and care of toenails (all except for patients with diabetes or vascular disease); bunions (except for capsular or bone surgery); fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.		Pages 35-36
Group Speech Therapy		Page 40
Gynecomastia - services for surgical treatments for cosmetic purposes		Page 36
Health club memberships, health spa charges, exercise equipment or classes, charges from a physical fitness instructor or personal trainer , any other charges for services, equipment, or facilities for developing or maintaining physical fitness, even when ordered by a physician.		Page 36
Hearing aids or the examination to prescribe or fit hearing aids, unless otherwise covered in the certificate.		Page 36
Home care services , including homemaker services; maintenance therapy; food and home-delivered meals; or custodial care and services.		Page 36

Excluded Services	Related State law(s) and/or Applicable Mandate for partial services	Benchmark Reference
The following services are specifically excluded in the benchmark plan, are not required, and may be excluded		
Hospital services that are non-covered include guest meals, telephones, televisions, and other convenience items; care by interns, residents, house physicians or other hospital employees billed separately; private room unless medically necessary.		Page 36
Immunizations for travel and work		Page 36
Long-Term/Custodial Nursing Home Care		Page 36
Services and supplies deemed not medically necessary		Page 37
The following mental health/substance use services : inpatient stays for environmental changes; cognitive rehabilitation therapy; educational therapy; vocational and recreational activities; coma stimulation therapy; services, surgeries and drugs to treat sexual deviation and dysfunction; treatment of social maladjustment without signs of a psychiatric disorder; or remedial or special education services.		Page 37
Medical Nutritional Therapy (Obesity); nutrition counseling , except when provided as part of diabetes education or when received as part of a covered wellness service visit or screening; nutritional and/or dietary supplements , except as required by law. This exclusion includes but is not limited to nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription.		Page 38

Excluded Services	Related State law(s) and/or Applicable Mandate for partial services	Benchmark Reference
The following services are specifically excluded in the benchmark plan, are not required, and may be excluded		
Obesity surgery, services, drugs or supplies; services, drugs, or supplies related to weight loss or dietary control even if there is a medical problem, including complications resulting from such surgeries or procedures. Services rendered to improve appearance following gastric bypass surgery, such as abdominoplasties, panniculectomies, and lipectomies.	38.2-3418.13	Page 38
Over-the-counter convenience and hygienic items		Page 34
Not included in the Prescription Drug benefit are: over-the-counter drugs, unless recommended by the US Preventive Services Task Force and prescribed by a physician; drugs for cosmetic purposes; drugs not approved by the FDA, or are experimental, investigational, except as required by law; charges to inject or administer drugs.	38.2-3407.5	Page 38
Private duty nursing in inpatient setting		Page 39

Excluded Services	Related State law(s) and/or Applicable Mandate for partial services	Benchmark Reference
The following services are specifically excluded in the benchmark plan, are not required, and may be excluded		

Recreation therapy , including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.		Page 37
Residential treatment center or care in other non-skilled setting , except when the center qualifies as a substance abuse treatment facility per Virginia law, and services are not merely custodial, residential, or domiciliary in nature.	38.2-3412.1	Page 39
Benefits for or related to sex transformation		Page 40
Skilled nursing facility stays are not covered for treatment of psychiatric conditions and senile deterioration; inpatient services during a temporary leave from a skilled nursing facility; or a private room unless medically necessary.		Page 40
Non-interactive telemedicine services, such as audio-only telephone conversations; electronic mail message, or fax transmissions.	38.2-3418.16	Page 40
Treatment of varicose veins or telangiectatic dermal veins (spider veins) when services are rendered for cosmetic purposes.		Page 40
TMJ Disorder Device (appliances for TMJ pain dysfunction)	38.2-3418.2	Page 35

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Excluded Services	Related State law(s) and/or Applicable Mandate for partial services	Benchmark Reference
The following services are specifically excluded in the benchmark plan, are not required, and may be excluded		
Adult Vision services or supplies unless needed due to eye surgery and accidental injury, including routine vision care and materials except as outlined in the coverage documents; services for radial keratotomy and other surgical procedures to correct refractive defects; keratoplasty; Lasik procedures; vision training and orthoptics; eyeglasses and eyewear, including sunglasses or safety glasses and accompanying frames.		Page 41
Work-related injuries or diseases when the employer must provide benefits or when that person has been paid by the employer.		Page 41