

Essential Health Benefits Checklist

Important Information

NOTE: This checklist was developed as a resource for carriers for product design purposes and to promote compliance with the essential health benefits requirements. This checklist 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 checklist 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.

This checklist, along with the applicable product checklist, must be completed in its entirety and submitted with each and any submission of a health insurance product to be issued in Virginia in the individual market and the small group market. The failure to submit this checklist, together with the completed product checklist, will result in delay of the review of the submission, and may result in the rejection of the filing.

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	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
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I. Ambulatory Patient Services

A. Primary Care Office Visit – Injury/ Illness	Code of Virginia § 38.2-3443	Including doctor visits in the home.		
B. Specialist Office Visit	38.2-3443			
C. Other Practitioner Office Visit (Nurse, Physician Assistant)		Includes Retail Health Clinics (walk-ins).		
D. Urgent Care Visit				
E. Ambulatory Surgery Center				
1. Facility Fee		Includes coverage for blood and blood products.		
2. Outpatient Surgery Physician/Surgical Services				
3. Medical and Surgical Supplies		Includes hypodermic needles and syringes.		
4. Anesthesia				

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F. Outpatient Hospital Facility				
1. Facility Fee		Includes coverage for blood and blood products.		
2. Professional Services at Hospital Outpatient Facility				
3. Medical and Surgical Supplies				
4. Anesthesia				
G. Radiation therapy				
1. Radiation Administration				
H. Respiratory therapy				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
I. Non-Emergency Care when Traveling Outside United States		Included in template, but not an EHB.		
J. Basic Adult Dental Care		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.		
K. Major Adult Dental Care		same as above		
L. Adult Orthodontia		same as above		
M. Non-routine Adult Eye Care		Vision corrected following surgery or accident. Glasses & contacts covered in such instances.		
N. Infusion Services - Inpatient, outpatient and home settings.		Infusion of therapeutic agents, medication and nutrients; infusion of enteral nutrition into the gastrointestinal tract; infusion of prescription medications.		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
O. Chemotherapy	38.2-3407.18			
P. Outpatient End Stage Renal Disease Treatment (Dialysis)		Includes hemodialysis and peritoneal dialysis.		
Q. Diagnostic Colonoscopy	38.2-3418.7:1			
R. Allergy Testing and Treatment				
S. In-home Hospice	38.2-3418.11			
T. Bones/Joints (TMJ diagnostic and Surgical Procedures)	38.2-3418.2	Does not cover appliances for temporomandibular joint pain dysfunction.		
U. Equipment /Supplies/ Therapy/ Training and Education for treatment of Lymphedema	38.2-3418.14			
V. Blood & Blood Services Hemophilia & Congenital Bleeding Disorders	38.2-3418.3			

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W. Clinical Trials for Cancer	38.2-3418.8			
X. Approved Clinical Trials for Life-threatening Diseases or Conditions	PHSA § 2709; 38.2-3453			
Y. Telemedicine	38.2-3418.16			
Z. Sleep Testing and Treatment				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
AA. Vision Correction after Surgery or Accident		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.		

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II. Emergency Services	PHSA § 2719A and 38.2-3445			
A. Emergency Room Professional Services				
B. Emergency Room Facility Services				
C. Emergency Transportation/ Ambulance (Vehicle)				
1. Emergency Transportation (Air)				
D. Out-of-Network Emergency Services		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).		

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E. Emergency Care Outside United States		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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III. Hospitalization

A. Inpatient Hospital Services		Covered for injury, illness, or pregnancy - to include drugs, injectable drugs, blood, oxygen, and nuclear medicine.		
1. Room and Board				
2. Professional Inpatient Services		Includes Physician, Surgical and General Nursing Services.		
3. Anesthesia				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
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			
5. Medical and Surgical Supplies		Includes hypodermic needles and syringes.		
B. Hospice	38.2-3418.11			
C. Skilled Nursing Facility		Includes room and board; rehabilitative services; and drugs, biologicals, and supplies. Minimum Requirement: 100 days per stay		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
D. Transplant Surgery – Recipient Charges		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.		
1. Transplant Surgery – Donor Charges		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	Covered to correct functional impairment, newborn congenital abnormalities.		
F. Oral and Maxillofacial Surgery	38.2-3418.2	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.		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
G. Reconstructive Breast Surgery following a Mastectomy	38.2-3418.4; 38.2-3418.6	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	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	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	Deemed medically necessary to attain functional capacity of the affected part.		
K. Hemophilia & Congenital Bleeding Disorders	38.2-3418.3			
L. Diagnostic Genetic Testing and Counseling	PHSA § 2705	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.		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
M. Clinical Trials for Cancer	38.2-3418.8 and PHSA § 2709	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				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
B. Services for interruption of pregnancy	PPACA § 1303; 38.2-3451	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.”		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
C. Prenatal and Postnatal Care	38.2-3442; 38.2-3407.16	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	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	Use of delivery room and care; anesthesia services. Minimum Requirement: Must conform with guidelines for perinatal care.		
1. Hospital Delivery Facility Fee				
2. Physician Services for Delivery				
F. Delivery by Midwife				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
G. Postnatal Care Services (Baby)	38.2-3411; 38.2-3442	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.		
H. Postpartum Care Services (Mother)	38.2-3414.1			
I. Routine Newborn Nursery & Care	38.2-3411, 38.2-3442	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	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.		

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A. Mental Health/Behavioral Health Outpatient Services		Visits for medication checks are covered. Includes diagnosis and treatment of psychiatric conditions, including psychotherapy, group psychotherapy, and psychological testing.		
1. Office based				
2. Outpatient Facility				
3. Outpatient Professional Services				
B. Mental Health/Behavioral Health Inpatient Services		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				
2. Inpatient Professional Services				
C. Substance Use Disorder Outpatient Services		Visits for medication checks are covered.		
1. Office based				
2. Outpatient Facility				

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3. Outpatient Professional Services				
D. Substance Use Disorder Inpatient Services/ Detoxification and Rehabilitation		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				
2. Inpatient Professional Services				
E. Partial Day/Intensive Outpatient Services		Partial Hospitalization is defined in 38.2-3412.1.		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
F. Residential Treatment Facilities / Centers (RTFs or RTCs)		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 Plan in each class or at least one in each class, whichever is greater.		
A. Generic Drugs, including Specialty and Biological Drugs				

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B. Preferred Brand Drugs, including Specialty and Biological Drugs				
C. Non-Preferred Brand Drugs, including Specialty and Biological Drugs				
D. Prescription Contraceptives	38.2-3407.5:1	<p>May be excluded for certain exempt religious groups. Covers FDA-approved contraceptive drugs and devices, and office visits associated with contraceptive management.</p> <p>Minimum Requirement: No cost sharing if covered.</p>		
E. Off-label drugs and cancer drugs	38.2-3407.5; 38.2-3407.6:1			

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
F. Medical Food supplements		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				
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				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
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1. Inpatient Rehabilitation Facility				
2. Inpatient Rehabilitation Professional Services				
B. Outpatient Rehabilitation Services				
1. Outpatient Rehabilitation Facility				
2. Outpatient Rehabilitation Professional Services				
C. Physical/Occupational Therapy		Minimum Requirement: 30 visits per calendar year combined for rehabilitative or habilitative services.		
D. Speech Therapy		Minimum Requirement: 30 visits per calendar year combined for rehabilitative or habilitative services.		
E. Other Rehabilitative/ Habilitative Therapies				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
1. Respiratory Therapy				
2. Cardiac Rehabilitation				
3. Early Intervention Services	38.2-3418.5	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.		
4. Private-Duty Nursing		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		Intermittent care provided in home. Includes visits by licensed health care professional (includes nurse, therapist, or home health aide) and physical, speech, and 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.		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
6. Chiropractic Care - Spinal manipulations and other manual medical interventions	38.2-3408	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		Covered only when prescribed as a result of surgery or for the treatment of accidental injury.		
2. Orthotics		Orthotics, other than foot orthotics, are covered, including cost of fitting, adjustment, and repair.		
3. Prosthetics	38.2-3418.15	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 halters; catheters and related supplies; and splints.		

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4. Durable Medical Equipment		Rental (or purchase if less expensive) covered when prescribed by doctor. Also, maintenance & necessary repairs covered except if damage is due to neglect. Covered equipment includes nebulizers, hospital-type beds, wheelchairs, traction equipment, walkers & crutches.		
5. Supplies	38.2-3418.10	Medical supplies, including those needed for diabetes care, as prescribed by a doctor.		
VIII. Laboratory Services				
A. Diagnostic Tests				
1. Radiology		Includes x-rays, mammograms, ultrasound, or nuclear medicine.		
2. Lab and Pathology Services				
3. EKGs, EEGs				
4. Advanced Imaging		Includes MRA, MRI, MRS, CTA, PET scans, CT scans, SPECT scans, and nuclear cardiology.		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
5. Professional Services for test interpretation, x-ray reading, lab interpretation, and scan reading				
IX. Preventive and Wellness Services and Chronic Disease Management	PHSA §2713			
A. Preventive Care/ Screening/ Immunization	38.2-3442; 38.2-3411.1			
1. Adult Routine Physical Exams or Immunizations		Covered at 100% under preventive care guidelines.		
2. Adult Routine Eye Exam and refraction		1 routine eye exam per calendar year (optional).		
B. Chronic Disease Care Management				

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
1. Diabetes Care Management	38.2-3418.10	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				
3. Dialysis Treatments in Facility or Doctor's Office				
4. Oxygen		Includes oxygen and equipment for its administration.		
5. Medical Formulas		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.		

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C. Wellness Services	38.2-3442	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	Must cover preventive screening by means stated in mandate provisions of Section 38.2-3418.7.		
2. Routine Mammography Screening	38.2-3418.1	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	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	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	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.		

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6. Smoking and Tobacco Cessation Counseling	38.2-3442			
7. Domestic Violence Screening and Counseling				
X. Pediatric Services, including Oral and Vision Care		At least up to age 19		
A. Well-Baby and Well-Child Care, including Immunizations	38.2-3411.3; 38.2-3442; and 38.2-3411.1	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	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.		

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Category	Federal & State Law/ Authority	Explanation	Identify document and Page #, Section and Para. addressing requirement	If not addressed or not applicable, use space below to explain
C. Routine Eye Exam	FEDVIP 2012 BlueVision High Option	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	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.		

4/23/13

Essential Health Benefits Benchmark Plan		
Excluded Services	Related State Law(s) and/or Applicable Mandate for partial services	Reference Page, Section and para. of the Plan
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	
Birthing Center		
Biofeedback Therapy, neurofeedback, and related testing.		
Cosmetic Surgery or procedures , including related procedures and complications that result from such surgeries or procedures.	38.2-3411 B	
Custodial or residential care in skilled nursing facility or other facility is not covered except for hospice care		
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.		
Donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate blood-related family members.		

4/23/13

Essential Health Benefits Benchmark Plan		
Excluded Services	Related State Law(s) and/or Applicable Mandate for partial services	Reference Page, Section and para. of the Plan
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 equipment; air conditioners, purifiers, and humidifiers; hypoallergenic bed linens; whirlpool baths; handrails, ramps, elevators, and 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.		
Durable Medical Equipment not appropriate for use in the home.		
Drugs for Certain Clinical Trials.	38.2-3418.8 and 38.2-3453	
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	
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	
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.		

Essential Health Benefits Benchmark Plan		
Excluded Services	Related State Law(s) and/or Applicable Mandate for partial services	Reference Page, Section and para. of the Plan
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.		
Group Speech Therapy		
Gynecomastia - services for surgical treatments for cosmetic purposes.		
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.		
Hearing aids or the examination to prescribe or fit hearing aids, unless otherwise covered in the certificate.		
Home care services , including homemaker services; maintenance therapy; food and home-delivered meals; or custodial care and services.		

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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.		
Immunizations for travel and work.		
Long-Term/Custodial Nursing Home Care		
Services and supplies deemed not medically necessary.		
The following mental health/substance abuse 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.		
Medical Nutritional Therapy (Obesity); nutrition counseling , except when provided as part of diabetes education or when received as part of a covered wellness services 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.		

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Essential Health Benefits Benchmark Plan		
Excluded Services	Related State Law(s) and/or Applicable Mandate for partial services	Reference Page, Section and para. of the Plan
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	
Over-the-counter convenience and hygienic items.		
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 or investigational, except as required by law; charges to inject or administer drugs.	38.2-3407.5	
Private duty nursing in inpatient setting.		
Recreation therapy , including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.		
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	
Benefits for or related to sex transformation.		

Essential Health Benefits Benchmark Plan		
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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.		
Non-interactive telemedicine services, such as audio-only telephone conversations; electronic mail message or fax transmissions.	38.2-3418.16	
Treatment of varicose veins or telangiectatic dermal veins (spider veins) when services are rendered for cosmetic purposes.		
TMJ Disorder Device (appliances for TMJ pain dysfunction).	38.2-3418.2	
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.		
Work-related injuries or diseases when the employer must provide benefits or when that person has been paid by the employer.		