

## KANSAS 2017 EHB BENCHMARK PLAN

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### SUMMARY INFORMATION

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|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <b>Plan Type</b>                                            | Small Group Market                                                                               |
| <b>Issuer Name</b>                                          | Blue Cross and Blue Shield of Kansas, Inc.                                                       |
| <b>Product Name</b>                                         | Comprehensive Major Medical - Blue Choice                                                        |
| <b>Plan Name</b>                                            | Comprehensive Major Medical - Blue Choice                                                        |
| <b>Supplemented Categories</b><br>(Supplementary Plan Type) | Pediatric dental (CHIP)<br>Pediatric vision (CHIP)<br>Habilitation services (Federal Definition) |

## BENEFITS AND LIMITS

| A<br>Benefit                                                 | B<br>EHB | C<br>Is the<br>Benefit<br>Covered? | D<br>Quantitative<br>Limit on<br>Service? | E<br>Limit<br>Quantity | F<br>Limit Unit | G<br>Exclusions                                                                                                                                                                                                                                                         | H<br>Explanations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| Primary Care Visit to Treat an Injury or Illness             | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Specialist Visit                                             | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         | Professional Providers include Physician Assistants. Registered Nurses qualify as Eligible Providers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)    | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Outpatient Surgery Physician/Surgical Services               | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Hospice Services                                             | Yes      | Covered                            | No                                        |                        |                 | Blood.                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Routine Dental Services (Adult)                              | No       | Not Covered                        | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Infertility Treatment                                        | Yes      | Covered                            | No                                        |                        |                 | Excludes In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure.                                                                                                                                                             | Plan covers Diagnosis and treatment of cause of infertility. Benefits are available for covered services such as office visits, laboratory tests, and radiological studies to diagnose the cause of infertility. Benefits are also provided for the necessary treatment of the condition unless the treatment is identified as non-covered (see exclusions). For example, corrective surgical procedures, therapeutic injections, and drug therapy regimens (Pregnyl, Clomid, Clomiphene, Ovidrel, Gonal, Follistim and Cetrotide) are all covered services when medically necessary. Benefits are also available for tests, such as ultrasound, performed to monitor the effectiveness of the fertility drug therapy. Also for any necessary pregnancy testing performed as an integral part of the overall infertility treatment program. Benefits are excluded, however, for any procedures, tests, or other services that are exclusively provided to monitor the effectiveness of non-covered fertilization procedures. |
| Long-Term/Custodial Nursing Home Care                        | No       | Not Covered                        | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Private-Duty Nursing                                         | Yes      | Covered                            | No                                        |                        |                 | Excludes services provided by a member of the Insured's immediate family; Provided by a person who normally lives in the Insured's home; or Which are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Routine Eye Exam (Adult)                                     | No       | Not Covered                        | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Urgent Care Centers or Facilities                            | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Home Health Care Services                                    | Yes      | Covered                            | No                                        |                        |                 | Excludes services provided by a member of the Insured's immediate family; Provided by a person who normally lives in the Insured's home; or Which are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care. | Includes educational visits with a limit of three per year on educational visits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Emergency Room Services                                      | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Emergency Transportation/Ambulance                           | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                         | Emergency transportation/ambulance within 500 mile radius.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Inpatient Hospital Services (e.g., Hospital Stay)            | Yes      | Covered                            | No                                        |                        |                 | Blood.                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| A<br>Benefit                                                  | B<br>EHB | C<br>Is the<br>Benefit<br>Covered? | D<br>Quantitative<br>Limit on<br>Service? | E<br>Limit<br>Quantity | F<br>Limit Unit           | G<br>Exclusions                                                                                                                                                                                                                                                                                                                                                                                                                  | H<br>Explanations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------|----------|------------------------------------|-------------------------------------------|------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Physician and Surgical Services</b>              | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Bariatric Surgery</b>                                      | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Cosmetic Surgery</b>                                       | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Skilled Nursing Facility</b>                               | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prenatal and Postnatal Care</b>                            | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  | Also covers surrogate mother if there is a petition to adopt within 90 days of birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Delivery and All Inpatient Services for Maternity Care</b> | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  | Also covers surrogate mother if there is a petition to adopt within 90 days of birth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Mental/Behavioral Health Outpatient Services</b>           | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Mental/Behavioral Health Inpatient Services</b>            | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Substance Abuse Disorder Outpatient Services</b>           | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Substance Abuse Disorder Inpatient Services</b>            | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Generic Drugs</b>                                          | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Preferred Brand Drugs</b>                                  | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Non-Preferred Brand Drugs</b>                              | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Specialty Drugs</b>                                        | Yes      | Covered                            | No                                        |                        |                           | Coverage for Specialty Prescription Drugs will be limited to a supply sufficient for 34 consecutive days of therapy.                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Outpatient Rehabilitation Services</b>                     | Yes      | Covered                            | Yes                                       | 90                     | Day(s) per Benefit Period | Excludes vocational rehabilitation; Cognitive therapy; social rehabilitation.                                                                                                                                                                                                                                                                                                                                                    | These therapies include but are not limited to PT, OT, and ST. Further, "[Rehab] Services are covered only if they are expected to result in significant improvement in the Insured's condition. The Company, with appropriate medical consultation, will determine whether significant improvement has occurred".<br><br>"Speech Therapy", limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. This limitation is not applicable to Mental Illness or Substance Use Disorders.                                                                      |
| <b>Habilitation Services</b>                                  | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  | Supplementing with the federal definition of habilitative services: "Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."                                                                                                                                         |
| <b>Chiropractic Care</b>                                      | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Durable Medical Equipment</b>                              | Yes      | Covered                            | No                                        |                        |                           | Items for comfort or convenience are not covered. Included within the definition of convenience items are:<br>(a) Pieces of equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility. (b) Those pieces of equipment designed to provide the walking capability for individuals with nonfunctioning legs. | "Benefits are limited to the amount normally available for a basic (standard) item which allows necessary function. Basic (standard) medical equipment is equipment that provides the essential function required for the treatment or amelioration of the medical condition at a Medically Necessary level. Charges for deluxe or electrically operated medical equipment are not covered, beyond the extent allowed for basic (standard) items. Deluxe describes medical equipment that has enhancements that allow for additional convenience or use beyond that provided by basic (standard) equipment." |

| A<br>Benefit                                                    | B<br>EHB | C<br>Is the<br>Benefit<br>Covered? | D<br>Quantitative<br>Limit on<br>Service? | E<br>Limit<br>Quantity | F<br>Limit Unit           | G<br>Exclusions                                                                                                                                                                                                                                                         | H<br>Explanations                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------|----------|------------------------------------|-------------------------------------------|------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hearing Aids                                                    | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Imaging (CT/PET Scans, MRIs)                                    | Yes      | Covered                            | No                                        |                        |                           | Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions. |                                                                                                                                                                                                                                                                                                                    |
| Preventive Care/Screening/Immunization                          | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Routine Foot Care                                               | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         | Covered when systemic conditions such as metabolic, neurologic, or peripheral vascular disease exists and results in medically significant circulatory deficits or decreased sensation to the foot.                                                                                                                |
| Acupuncture                                                     | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Weight Loss Programs                                            | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Routine Eye Exam for Children                                   | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Eye Glasses for Children                                        | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Dental Check-Up for Children                                    | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Rehabilitative Speech Therapy                                   | Yes      | Covered                            | Yes                                       | 90                     | Day(s) per Benefit Period |                                                                                                                                                                                                                                                                         | Limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. This limitation is not applicable to Mental Illness or Substance Use Disorders.                                                                                                                        |
| Rehabilitative Occupational and Rehabilitative Physical Therapy | Yes      | Covered                            | No                                        |                        |                           | Materials used for occupational therapy are excluded.                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                    |
| Well Baby Visits and Care                                       | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Laboratory Outpatient and Professional Services                 | Yes      | Covered                            | No                                        |                        |                           | Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions. |                                                                                                                                                                                                                                                                                                                    |
| X-rays and Diagnostic Imaging                                   | Yes      | Covered                            | No                                        |                        |                           | Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions. |                                                                                                                                                                                                                                                                                                                    |
| Basic Dental Care - Child                                       | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Orthodontia - Child                                             | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         | Orthodontic services require prior authorization and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time. |
| Major Dental Care - Child                                       | Yes      | Covered                            | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Basic Dental Care - Adult                                       | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                         | Basic dental care for adults not covered by CHIP.                                                                                                                                                                                                                                                                  |
| Orthodontia - Adult                                             | No       | Not Covered                        | No                                        |                        |                           |                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
| Major Dental Care – Adult                                       | No       | Not Covered                        | No                                        |                        |                           | Major dental care for adults not covered by CHIP.                                                                                                                                                                                                                       | Major dental care for adults not covered by CHIP.                                                                                                                                                                                                                                                                  |
| Abortion for Which Public Funding is Prohibited                 | No       | Not Covered                        | No                                        |                        |                           | Voluntary Abortions.                                                                                                                                                                                                                                                    | Covered when life of the mother is in jeopardy.                                                                                                                                                                                                                                                                    |
| Transplant                                                      | Yes      | Covered                            | No                                        |                        |                           | There is no coverage hereunder for any transplant not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered.                                                       | Benefits are provided for the following human organ transplants: Cornea; heart; heart-lung; kidney; pancreas; liver; lung (whole or lobar, single or double); small intestine; and multivisceral transplants.                                                                                                      |

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|--------------------|----------|------------------------------------|-------------------------------------------|------------------------|-----------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accidental Dental  | Yes      | Covered                            | No                                        |                        |                 |                 | <p>Oral Surgical Services and Services for Accidental Injuries to Sound Natural Teeth, limited to:</p> <p>(1) Surgical procedures of the jaw and gums.</p> <p>(2) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.</p> <p>(3) Removal of exostoses (bony growths) of the jaw and hard palate.</p> <p>(4) Treatment of fractures and dislocations of the jaw and facial bones.</p> <p>(5) Surgical removal of impacted teeth.</p> <p>(6) Treatment of Sound Natural Teeth caused by an Accidental Injury. This includes replacement of Sound Natural Teeth lost due to the Accidental Injury.</p> <p>(7) Intra oral dental imaging services in connection with covered oral surgery if treatment begins within 30 days.</p> <p>(8) General anesthesia for covered oral surgery.</p> <p>(9) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury.</p> <p>(10) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliances following surgical resection of either benign or malignant lesions (NOT including inflammatory lesions).</p> |
| Dialysis           | Yes      | Covered                            | No                                        |                        |                 |                 | Plan cover Hemodialysis.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Allergy Testing    | Yes      | Covered                            | No                                        |                        |                 |                 | Allergy testing and treatment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Chemotherapy       | Yes      | Covered                            | No                                        |                        |                 |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Radiation          | Yes      | Covered                            | No                                        |                        |                 |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Diabetes Education | Yes      | Covered                            | No                                        |                        |                 |                 | <p>Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association; (2) is treated by a person certified by the national certification board of diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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| <b>Prosthetic Devices</b>                              | Yes      | Covered                            | No                                        |                        |                 | (1) Benefits are not provided for eyeglasses and contact lenses. Exception: Benefits are available for the initial eyeglasses/contacts following surgery for cataracts, aphakia, or pseudophakia, or an Insured under 12 years of age is eligible for subsequent eyeglasses/contacts following cataract surgery when there is a minimum change of .25 diopter. (2) Benefits are not provided for hearing aids, hair prosthesis or dental appliances including plates, bridges, prostheses or braces. (3) Benefits are not provided for items of wearing apparel except coverage is available for two postmastectomy bras per Insured per Benefit Period. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses. (4) Benefits are limited to the allowable amount for a basic/standard appliance which provides the essential function(s) required for the treatment or amelioration of the medical condition. (5) Charges for deluxe or electrically operated appliances or devices are not covered beyond the allowable amount for basic/standard appliances. Deluxe describes medical devices or appliances that have enhancements that allow for additional convenience or use beyond that provided by a basic/standard device or appliance. (6) Benefits are not provided for custom or over-the-counter orthotic devices, appliances including shoe inserts. | Benefits are limited to the amount normally available for a basic (standard) appliance which allows necessary function. Basic (standard) medical devices or appliances are those that provide the essential function required for the treatment or amelioration of the medical condition at a Medically Necessary level. |
| <b>Infusion Therapy</b>                                | Yes      | Covered                            | No                                        |                        |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                          |
| <b>Treatment for Temporomandibular Joint Disorders</b> | Yes      | Covered                            | No                                        |                        |                 | Phase II irreversible treatment; equilibration of occlusion, coronoplasty, occlusal adjustment; slides and/or photographs; non-prescription drugs, vitamins, nutrition supplements; stretching and other exercises; coolant sprays; moist heat therapy; hot packs; massage, either manual or by machine; acupuncture; cold packs; range of motion treatments; diet survey; nutrition counseling; rental or purchase of transcutaneous electrical nerve stimulators; office visits; periapical, bitewing and full-mouth radiographs; orthodontic treatment, including both fixed and removable appliances used for the purpose of moving teeth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                          |
| <b>Nutritional Counseling</b>                          | No       | Not Covered                        | No                                        |                        |                 | Specifically excluded for obesity management.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | This category signifies a benefit beyond that required under USPSTF AB Preventive Services.                                                                                                                                                                                                                              |

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| Reconstructive Surgery | Yes      | Covered                            | No                                        |                        |                 |                 | <p>Cosmetic and reconstructive are generally excluded, but excepted from this exclusion are:</p> <p>a. Cosmetic or reconstructive repair of an Accidental Injury.</p> <p>b. Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance.</p> <p>c. Repair of congenital abnormalities and hereditary complications or conditions, limited to: (1) Cleft lip or palate. (2) Birthmarks on head or neck. (3) Webbed fingers or toes. (4) Supernumerary fingers or toes.</p> <p>d. Reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes. For purposes of this provision, the term "cosmetic" means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.</p> |

## PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

| CATEGORY                                         | CLASS                                                                                                   | SUBMISSION COUNT |
|--------------------------------------------------|---------------------------------------------------------------------------------------------------------|------------------|
| Analgesics                                       | Nonsteroidal Anti-inflammatory Drugs                                                                    | 20               |
| Analgesics                                       | Opioid Analgesics, Long-acting                                                                          | 10               |
| Analgesics                                       | Opioid Analgesics, Short-acting                                                                         | 12               |
| Anesthetics                                      | Local Anesthetics                                                                                       | 3                |
| Anti-Addiction/ Substance Abuse Treatment Agents | Alcohol Deterrents/Anti-craving                                                                         | 3                |
| Anti-Addiction/ Substance Abuse Treatment Agents | Opioid Dependence Treatments                                                                            | 2                |
| Anti-Addiction/ Substance Abuse Treatment Agents | Opioid Reversal Agents                                                                                  | 1                |
| Anti-Addiction/ Substance Abuse Treatment Agents | Smoking Cessation Agents                                                                                | 3                |
| Antibacterials                                   | Aminoglycosides                                                                                         | 5                |
| Antibacterials                                   | Antibacterials, Other                                                                                   | 17               |
| Antibacterials                                   | Beta-lactam, Cephalosporins                                                                             | 10               |
| Antibacterials                                   | Beta-lactam, Other                                                                                      | 2                |
| Antibacterials                                   | Beta-lactam, Penicillins                                                                                | 5                |
| Antibacterials                                   | Macrolides                                                                                              | 5                |
| Antibacterials                                   | Quinolones                                                                                              | 10               |
| Antibacterials                                   | Sulfonamides                                                                                            | 4                |
| Antibacterials                                   | Tetracyclines                                                                                           | 4                |
| Anticonvulsants                                  | Anticonvulsants, Other                                                                                  | 4                |
| Anticonvulsants                                  | Calcium Channel Modifying Agents                                                                        | 4                |
| Anticonvulsants                                  | Gamma-aminobutyric Acid (GABA) Augmenting Agents                                                        | 4                |
| Anticonvulsants                                  | Glutamate Reducing Agents                                                                               | 3                |
| Anticonvulsants                                  | Sodium Channel Agents                                                                                   | 7                |
| Antidementia Agents                              | Antidementia Agents, Other                                                                              | 1                |
| Antidementia Agents                              | Cholinesterase Inhibitors                                                                               | 3                |
| Antidementia Agents                              | N-methyl-D-aspartate (NMDA) Receptor Antagonist                                                         | 1                |
| Antidepressants                                  | Antidepressants, Other                                                                                  | 8                |
| Antidepressants                                  | Monoamine Oxidase Inhibitors                                                                            | 4                |
| Antidepressants                                  | SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors) | 11               |
| Antidepressants                                  | Tricyclics                                                                                              | 9                |
| Antiemetics                                      | Antiemetics, Other                                                                                      | 10               |
| Antiemetics                                      | Emetogenic Therapy Adjuncts                                                                             | 6                |
| Antifungals                                      | No USP Class                                                                                            | 20               |
| Antigout Agents                                  | No USP Class                                                                                            | 6                |
| Anti-inflammatory Agents                         | Glucocorticoids                                                                                         | 26               |
| Anti-inflammatory Agents                         | Nonsteroidal Anti-inflammatory Drugs                                                                    | 20               |
| Antimigraine Agents                              | Ergot Alkaloids                                                                                         | 2                |

| CATEGORY              | CLASS                                                                              | SUBMISSION COUNT |
|-----------------------|------------------------------------------------------------------------------------|------------------|
| Antimigraine Agents   | Prophylactic                                                                       | 3                |
| Antimigraine Agents   | Serotonin (5-HT) 1b/1d Receptor Agonists                                           | 7                |
| Antimyasthenic Agents | Parasympathomimetics                                                               | 3                |
| Antimycobacterials    | Antimycobacterials, Other                                                          | 2                |
| Antimycobacterials    | Antituberculars                                                                    | 10               |
| Antineoplastics       | Alkylating Agents                                                                  | 4                |
| Antineoplastics       | Antiandrogens                                                                      | 4                |
| Antineoplastics       | Antiangiogenic Agents                                                              | 2                |
| Antineoplastics       | Antiestrogens/Modifiers                                                            | 3                |
| Antineoplastics       | Antimetabolites                                                                    | 4                |
| Antineoplastics       | Antineoplastics, Other                                                             | 4                |
| Antineoplastics       | Aromatase Inhibitors, 3rd Generation                                               | 3                |
| Antineoplastics       | Enzyme Inhibitors                                                                  | 3                |
| Antineoplastics       | Molecular Target Inhibitors                                                        | 13               |
| Antineoplastics       | Monoclonal Antibodies                                                              | 1                |
| Antineoplastics       | Retinoids                                                                          | 3                |
| Antiparasitics        | Anthelmintics                                                                      | 3                |
| Antiparasitics        | Antiprotozoals                                                                     | 11               |
| Antiparasitics        | Pediculicides/Scabicides                                                           | 6                |
| Antiparkinson Agents  | Anticholinergics                                                                   | 3                |
| Antiparkinson Agents  | Antiparkinson Agents, Other                                                        | 3                |
| Antiparkinson Agents  | Dopamine Agonists                                                                  | 4                |
| Antiparkinson Agents  | Dopamine Precursors/ L-Amino Acid Decarboxylase Inhibitors                         | 2                |
| Antiparkinson Agents  | Monoamine Oxidase B (MAO-B) Inhibitors                                             | 2                |
| Antipsychotics        | 1st Generation/Typical                                                             | 10               |
| Antipsychotics        | 2nd Generation/Atypical                                                            | 9                |
| Antipsychotics        | Treatment-Resistant                                                                | 1                |
| Antispasticity Agents | No USP Class                                                                       | 4                |
| Antivirals            | Anti-cytomegalovirus (CMV) Agents                                                  | 2                |
| Antivirals            | Anti-hepatitis B (HBV) Agents                                                      | 7                |
| Antivirals            | Anti-hepatitis C (HCV) Agents                                                      | 7                |
| Antivirals            | Antitherpetic Agents                                                               | 5                |
| Antivirals            | Anti-HIV Agents, Integrase Inhibitors (INSTI)                                      | 2                |
| Antivirals            | Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)           | 5                |
| Antivirals            | Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI) | 12               |
| Antivirals            | Anti-HIV Agents, Other                                                             | 3                |
| Antivirals            | Anti-HIV Agents, Protease Inhibitors                                               | 9                |
| Antivirals            | Anti-influenza Agents                                                              | 4                |

| CATEGORY                                   | CLASS                                                                                                   | SUBMISSION COUNT |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------|------------------|
| Anxiolytics                                | Anxiolytics, Other                                                                                      | 4                |
| Anxiolytics                                | Benzodiazepines                                                                                         | 0                |
| Anxiolytics                                | SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors) | 5                |
| Bipolar Agents                             | Bipolar Agents, Other                                                                                   | 7                |
| Bipolar Agents                             | Mood Stabilizers                                                                                        | 5                |
| Blood Glucose Regulators                   | Antidiabetic Agents                                                                                     | 21               |
| Blood Glucose Regulators                   | Glycemic Agents                                                                                         | 1                |
| Blood Glucose Regulators                   | Insulins                                                                                                | 10               |
| Blood Products/Modifiers/ Volume Expanders | Anticoagulants                                                                                          | 7                |
| Blood Products/Modifiers/ Volume Expanders | Blood Formation Modifiers                                                                               | 6                |
| Blood Products/Modifiers/ Volume Expanders | Coagulants                                                                                              | 0                |
| Blood Products/Modifiers/ Volume Expanders | Platelet Modifying Agents                                                                               | 8                |
| Cardiovascular Agents                      | Alpha-adrenergic Agonists                                                                               | 4                |
| Cardiovascular Agents                      | Alpha-adrenergic Blocking Agents                                                                        | 4                |
| Cardiovascular Agents                      | Angiotensin II Receptor Antagonists                                                                     | 8                |
| Cardiovascular Agents                      | Angiotensin-converting Enzyme (ACE) Inhibitors                                                          | 10               |
| Cardiovascular Agents                      | Antiarrhythmics                                                                                         | 10               |
| Cardiovascular Agents                      | Beta-adrenergic Blocking Agents                                                                         | 13               |
| Cardiovascular Agents                      | Calcium Channel Blocking Agents                                                                         | 9                |
| Cardiovascular Agents                      | Cardiovascular Agents, Other                                                                            | 4                |
| Cardiovascular Agents                      | Diuretics, Carbonic Anhydrase Inhibitors                                                                | 2                |
| Cardiovascular Agents                      | Diuretics, Loop                                                                                         | 4                |
| Cardiovascular Agents                      | Diuretics, Potassium-sparing                                                                            | 4                |
| Cardiovascular Agents                      | Diuretics, Thiazide                                                                                     | 6                |
| Cardiovascular Agents                      | Dyslipidemics, Fibric Acid Derivatives                                                                  | 2                |
| Cardiovascular Agents                      | Dyslipidemics, HMG CoA Reductase Inhibitors                                                             | 7                |
| Cardiovascular Agents                      | Dyslipidemics, Other                                                                                    | 7                |
| Cardiovascular Agents                      | Vasodilators, Direct-acting Arterial                                                                    | 3                |
| Cardiovascular Agents                      | Vasodilators, Direct-acting Arterial/Venous                                                             | 3                |
| Central Nervous System Agents              | Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines                                       | 4                |
| Central Nervous System Agents              | Attention Deficit Hyperactivity Disorder Agents, Amphetamines                                           | 4                |
| Central Nervous System Agents              | Central Nervous System, Other                                                                           | 7                |
| Central Nervous System Agents              | Fibromyalgia Agents                                                                                     | 3                |
| Central Nervous System Agents              | Multiple Sclerosis Agents                                                                               | 6                |
| Dental and Oral Agents                     | No USP Class                                                                                            | 8                |
| Dermatological Agents                      | No USP Class                                                                                            | 84               |
| Enzyme Replacement/ Modifiers              | No USP Class                                                                                            | 7                |
| Gastrointestinal Agents                    | Antispasmodics, Gastrointestinal                                                                        | 4                |

| CATEGORY                                                                     | CLASS                                           | SUBMISSION COUNT |
|------------------------------------------------------------------------------|-------------------------------------------------|------------------|
| Gastrointestinal Agents                                                      | Gastrointestinal Agents, Other                  | 9                |
| Gastrointestinal Agents                                                      | Histamine2 (H2) Receptor Antagonists            | 4                |
| Gastrointestinal Agents                                                      | Irritable Bowel Syndrome Agents                 | 3                |
| Gastrointestinal Agents                                                      | Laxatives                                       | 4                |
| Gastrointestinal Agents                                                      | Protectants                                     | 2                |
| Gastrointestinal Agents                                                      | Proton Pump Inhibitors                          | 3                |
| Genitourinary Agents                                                         | Antispasmodics, Urinary                         | 7                |
| Genitourinary Agents                                                         | Benign Prostatic Hypertrophy Agents             | 9                |
| Genitourinary Agents                                                         | Genitourinary Agents, Other                     | 6                |
| Genitourinary Agents                                                         | Phosphate Binders                               | 3                |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)                 | No USP Class                                    | 31               |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)          | No USP Class                                    | 1                |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers) | Anabolic Steroids                               | 2                |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers) | Androgens                                       | 4                |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers) | Estrogens                                       | 6                |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers) | Progesterone Agonists/Antagonists               | 0                |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers) | Progestins                                      | 5                |
| Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers) | Selective Estrogen Receptor Modifying Agents    | 1                |
| Hormonal Agents, Stimulant/Replacement/ Modifying (Pituitary)                | No USP Class                                    | 5                |
| Hormonal Agents, Stimulant/Replacement/ Modifying (Thyroid)                  | No USP Class                                    | 3                |
| Hormonal Agents, Suppressant (Adrenal)                                       | No USP Class                                    | 1                |
| Hormonal Agents, Suppressant (Parathyroid)                                   | No USP Class                                    | 3                |
| Hormonal Agents, Suppressant (Pituitary)                                     | No USP Class                                    | 7                |
| Hormonal Agents, Suppressant (Thyroid)                                       | Antithyroid Agents                              | 2                |
| Immunological Agents                                                         | Angioedema (HAE) Agents                         | 1                |
| Immunological Agents                                                         | Immune Suppressants                             | 18               |
| Immunological Agents                                                         | Immunizing Agents, Passive                      | 0                |
| Immunological Agents                                                         | Immunomodulators                                | 14               |
| Inflammatory Bowel Disease Agents                                            | Aminosaliclates                                 | 3                |
| Inflammatory Bowel Disease Agents                                            | Glucocorticoids                                 | 5                |
| Inflammatory Bowel Disease Agents                                            | Sulfonamides                                    | 1                |
| Metabolic Bone Disease Agents                                                | No USP Class                                    | 14               |
| Ophthalmic Agents                                                            | Ophthalmic Prostaglandin and Prostanoid Analogs | 3                |
| Ophthalmic Agents                                                            | Ophthalmic Agents, Other                        | 20               |
| Ophthalmic Agents                                                            | Ophthalmic Anti-allergy Agents                  | 9                |
| Ophthalmic Agents                                                            | Ophthalmic Antiglaucoma Agents                  | 17               |
| Ophthalmic Agents                                                            | Ophthalmic Anti-inflammatories                  | 11               |
| Otic Agents                                                                  | No USP Class                                    | 8                |

| CATEGORY                                      | CLASS                                         | SUBMISSION COUNT |
|-----------------------------------------------|-----------------------------------------------|------------------|
| Respiratory Tract/ Pulmonary Agents           | Antihistamines                                | 11               |
| Respiratory Tract/ Pulmonary Agents           | Anti-inflammatories, Inhaled Corticosteroids  | 7                |
| Respiratory Tract/ Pulmonary Agents           | Antileukotrienes                              | 3                |
| Respiratory Tract/ Pulmonary Agents           | Bronchodilators, Anticholinergic              | 3                |
| Respiratory Tract/ Pulmonary Agents           | Bronchodilators, Sympathomimetic              | 10               |
| Respiratory Tract/ Pulmonary Agents           | Cystic Fibrosis Agents                        | 3                |
| Respiratory Tract/ Pulmonary Agents           | Mast Cell Stabilizers                         | 1                |
| Respiratory Tract/ Pulmonary Agents           | Phosphodiesterase Inhibitors, Airways Disease | 5                |
| Respiratory Tract/ Pulmonary Agents           | Pulmonary Antihypertensives                   | 6                |
| Respiratory Tract/ Pulmonary Agents           | Respiratory Tract Agents, Other               | 2                |
| Skeletal Muscle Relaxants                     | No USP Class                                  | 6                |
| Sleep Disorder Agents                         | GABA Receptor Modulators                      | 3                |
| Sleep Disorder Agents                         | Sleep Disorders, Other                        | 5                |
| Therapeutic Nutrients/ Minerals/ Electrolytes | Electrolyte/Mineral Modifiers                 | 7                |
| Therapeutic Nutrients/ Minerals/ Electrolytes | Electrolyte/Mineral Replacement               | 7                |
| Therapeutic Nutrients/ Minerals/ Electrolytes | Vitamins                                      | 0                |