BENCHMARK 2017 PLAN OPTIONS CHART

Note: This chart displays information presently available to HBX. HBX does not have access to limitations and exclusions langauge, and definitions for all plans

May 18, 2015

		Plan A (SG) GHMSI BluePrefered PPO $1,000 – 100%/80% PPO	Plan B (SG)CareFirst HealthyBlue Advantage $1,500 HMO	Plan C (SG) KPSG DC Platinum 0/20 OFF SIG ++ HMO	Plan D BlueChoice HMO DC Option 13 HMO	Plan E (FEHBP) BCBS FFS Standard HMO	Plan F (FEHBP) BCBS FFS Basic HMO	Plan G (FEHBP) Government Employee Health Association (GEHA) Plan FFS Standard	Plan H (DC employee) Aetna HMO Plan DC GOV --Not Yet Available--	Plan I (DC employee) Aetna PPO Plan DCGOV	Plan J (DC employee) Kaiser HMO Plan DC GOV
EHB Required Benefit	**Benefit Detail(s)**	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*	**Coverage Details** *i.e. covered/not covered, applicable limits*
Ambulatory Patient Services											
	Office visits	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Outpatient hospital facility services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Ambulatory surgical facility services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Professional medical services provided at care facility	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Professional surgical services provided at care facility	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Home health services	Covered 90 days per episode	Covered 90 days per episode	Covered 90 visits and up to 4 hours per episode of care	Number of visit not limited	Covered 2 hrs/day	Covered 2 hrs/day	Covered 2 hrs/day 50 visits		Covered 60 days	Covered (limited to 2 hours per visit and 3 visits per day)
Emergency Coverage											
	Emergency room services (including voluntary HIV test performed while receiving emergency medical services at a hospital ER)	Covered	Covered	Covered	Covered	Covered	Covered	Covered - care received within 72 hours of accident		Covered (does not specifically list coveage of HIV test)	Covered
	Ambulance service	Covered	Covered	Covered	Not listed specifically	Covered	Covered	Covered - w/in 72 hours of an accident. Air only covered if no ground transport is available or suitable.		Covered	Covered
Hospitalization											
	Inpatient facility services (medical or surgical condition)	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Hospitalization for rehab	Covered 90 days per benefit period	Covered 90 days per benefit period	Covered	Covered	Covered	Covered	Covered		?Not listed specifically	Covered
	Inpatient professional medical services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Inpatient professional surgical services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Anesthesia services	?Not listed specifically	Not listed specifically			Covered	Covered	Covered		Covered	Covered
	Hospice services	Covered	Covered	Covered 180 days per eligibility period	Covered	Covered	Covered	Covered		Covered	Covered up to $15,000
Maternity/Newborn Care											
	Pre-natal care	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Post-natal care	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Not listed specifically	Covered
	Labor and delivery	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Inpatient facility services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Routine newborn care	Covered (not specifically listed but presumably covered under well-child)	Covered (not specifically listed but presumably covered under well-child)	Covered	Covered	Covered	Covered	Covered		Not listed specifically	Covered
	Postpartum home visits	Covered	Covered	Covered	Covered	Covered	Covered	(not specifically listed but appears to be covered under home health benefit)		Not listed specifically	Covered
Mental Health, Substance Use Disorders, Behavioral Health Treatment - Note: ABA is applied behavior analysis											
	Mental health outpatient services	Covered	Covered	Covered	Covered	Covered	Covered	Covered - excludes treatment for learning disabilites and mental retardation. Excludes telephone therapy. Excludes marriage counseling and ABA.		Covered	Covered (Excludes CBT and ABA)
	Substance abuse outpatient services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Medication management office visits	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Not listed specifically	Covered
	Inpatient mental health facility services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Inpatient substance abuse facility services	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Detoxification	Not listed specifically	Not listed specifically	Covered	Covered			Covered		Not listed specifically	Covered (Minimum of 12 days)
	Partial hospitalization	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Not listed specifically	Covered
Prescription Drugs											
	Preferred preventive drugs	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Not listed specifically
	Generic drugs	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
	Preferred brand name drugs	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
	Non-preferred brand name drugs	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
	Diabetic supplies	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
	Oral chemotherapy drugs	Covered	Covered	Covered	Not yet available	Not listed specifically	Not listed specifically	Not listed specifically		Not listed specifically	Covered

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	Injectable, self-administered medications			Covered	Not yet available	Covered	Not Covered	Covered		?Not listed specifically	Covered
	Prescription drugs (general)	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
	Maintenance drugs (general)	Covered	Covered	Covered	Not yet available	Not listed specifically	Not listed specifically	Covered		Not listed specifically	Covered
	Contraception	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
Rehabilitative & Habilitative Services and Devices											
	Rehabilitation services	Covered	Covered	Covered - excludes the following habilitative services: assistive technology services and devices. Also "no coverage is provided for any therapy that the plan Dr determines cannot acheive measurable improvement in function within a 90-day period."	Covered	Covered	Covered	Covered up to 60 visits (limit applies to both rehab and Habiliative services) (combined, PT, OT and ST) Excludes maintence therapy, computer decides to assist with communcation, computer programs of any type, services intended to teach or enhance instrumental activities of daily living		60 days per calendar year (covers rehab, does not specify habilitation)	Covered for up to 90 days per incident
	Spinal manipulation services	Covered	Covered	Covered- limited to members 12 years of age and older	Covered	Covered	Covered	Covered up to 12 visits		Covered	Covered
	Habilitative services for children	Covered	Covered	Covered- excludes assistive technology services and devices	Covered	Not covered	Not covered	Covered - limited to 60 visits per calendar year (applies to both rehab and habilitation)		Not listed specifically	Under age 21 with congenital or birth defect
	Cardiac rehab	Covered 90 days per benefit period	Covered 90 days per benefit period	Covered - up to 90 consecutive days	Covered	Covered	Covered	Covered		Not listed specifically	Covered 12 weeks or 36 sessions
	Pulmonary rehabilitation	Covered - limited to one program per lifetime	Covered - limited to one program per lifetime	Covered - limited to one program per lifetime	Covered	Covered	Covered	Not covered		Not listed specifically	?Not listed specifically
	Skilled nursing facility services	Covered 60 days per benefit period	Covered 60 days per benefit period	Covered 60 days per benefit period	Covered	Covered only for Medicare Part A enrollees	Not covered	Covered 14 days post-discharge		Covered 60 day	Covered 90 days per incident
	Medical devices and supplies	Covered	Covered	Covered- excludes modifications to home or car, electronic monitoring of the heart or lungs- except infant apnea monitors.	Covered	Covered	Covered	Covered: Excludes wigs, computer programs of any type, lifts		Covered	Covered (excludes sleep apnea machines for adults and kids over age 3, modifications to car or home, devices for testing blood or other bodily fluuds (other than those covered under diabetes care)
Laboratory Services											
	Laboratory tests	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	X-rays and other diagnostic procedures	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
Preventive and Wellness Services											
	Adult routine physical exam	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Routine gynecological exam	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
	Prostate cancer screening	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Pap smear	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Mammography	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Colorectal cancer screening	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Immunizations	Covered	Covered	Covered	Covered	Covered	Covered	Covered		Covered	Covered
	Medical nutrition therapy	Covered	Covered	Covered	Not yet available	Not listed specifically	Not covered	Not covered		Not covered	Covered
	Professional nutritional counseling	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Not covered	Not listed specifically
	Allergy testing, treatment, and shots	Covered	Covered	Covered	Covered	Covered	Covered	Covered- limited to 100 tests per person per calendar year. Excludes provocative food testing and sublingual allergy desensitization		Covered	Covered
	Diabetes treatment	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
Pediatric Services, including Dental and Vision					Plan documents say that "pediatric services, including oral and vision care" is covered. No further detail available.						
	Well-child care	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Covered	Covered
	Preventive services for obesity	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Covered		Not listed specifically but outpatient obesity treatment is covered	
	Vision-eye exam (separate visit)	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Covered		Covered	Covered
	Vision-lenses	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Not covered		Not covered	Covered
	Vision-frames	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Not covered		Not covered	Covered
	Vision-contact lenses	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Not covered		Not covered	Covered
	Dental Class I - preventive and diagnostic	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered		Not covered	Covered
	Dental Class II - basic services	Covered	Covered	Covered	Not yet available	Covered	Covered	Covered**		Not covered	Not covered

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	Dental Class III - major services - surgical	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Not covered**		Not covered	Not covered
	Dental Class IV - major services - restorative	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Not covered**		Not covered	Not covered
	Dental Class V - orthodontia (medically necessary)	Covered	Covered	Covered	Not yet available	Not covered	Not covered	Not covered		Not covered	Not covered
Prescription Drug Formulary											
	Posted as a Separate Attachment	Posted as a Separate Attachment	Posted as a Separate Attachment	Posted as a Separate Attachment	Not yet available	Not yet available	Not yet available	Not yet available	Not yet available	Not yet available	Not yet available

** Plan Documents Say Coverage Includes the Following: Amalgams, restorations, gold foil, simple extractions