

Maine Bureau of Insurance

2017 BENCHMARK ESSENTIAL HEALTH BENEFITS CHART

Please note that all benefits must be listed in the policy/certificate and schedule of benefits.

Confirm compliance and IDENTIFY the specific LOCATION (page number, section, paragraph, etc.) of the BENEFIT in the last column.

(Revised 4/15/2016)

| REQUIRED BENEFIT | DESCRIPTION OF BENEFIT | CONFIRM COMPLIANCE AND IDENTIFY SPECIFIC LOCATION OF BENEFIT IN FILING |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Allergy Testing and Injections | Provide benefits for allergy testing and injections. | |
| Ambulance Services | Provide benefits for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. The carrier may specify circumstances for which this service is covered. | |
| Ambulatory Surgery Centers | Provide benefits for certain covered services provided by ambulatory surgery centers. | |
| Anesthesia Services | Provide benefits for anesthesia only if administered while a Covered Service is being provided, except as outlined in the 'Dental Procedures' provision. | |
| Autism Spectrum Disorders | <p>Provide coverage for members for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. The carrier may specify that a licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.</p> <p>The policy or contract may limit coverage for applied behavior analysis to the actuarial equivalent of at least \$36,000 worth of visits/services per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.</p> | |

| | | |
|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | <p>Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition.</p> | |
| Blood Transfusions | Provide benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations. | |
| Chemotherapy Services | Provide benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by the carrier for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the carrier for medically accepted indications or as required by law. | |
| Chiropractic Care/ Manipulative Therapy | <p>Provide benefits for chiropractic care and manipulative therapy for treating acute musculo-skeletal disorders. No benefits are provided for ancillary treatment such as massage therapy, heat, and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for Maintenance Therapy for chronic conditions.</p> <p>Must provide at least 40 visits per year.</p> | |
| Clinical Trials | Benefits include coverage for services given to the member as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated. | |
| Contraceptives/Family Planning | Provide benefits for family planning and prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis. | |
| Dental Procedures | Provide benefits for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the Member is classified as vulnerable. | |
| Dental Services | Provide benefits only for the following: Setting a jaw fracture, removing | |

| | | |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | a tumor (but not a root cyst), removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting, treatment within six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later, repairing or replacing dental prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later. | |
| Diabetic Services | Provide benefits for diabetes medication, equipment, and supplies which are medically appropriate and necessary. Benefits are limited to: insulin, insulin pumps, oral hypoglycemic agents, glucose monitors, test strips, syringes, lancets, and Outpatient self-management and educational services used to treat diabetes if services are provided through a program that is authorized by the Maine Diabetes Prevention and Control Program within the Center for Disease Control and Prevention. | |
| Diagnostic Services | Provide benefits for Diagnostic Services, including diagnostic laboratory tests and x-rays, when they are ordered by a provider to diagnose specific signs or symptoms of an illness or injury or when the services are part of well-baby or well-adult care stated as covered under this contract. | |
| Durable Medical Equipment and Prostheses | Provide benefits for the rental or purchase of the least expensive Durable Medical Equipment necessary to meet your medical needs. If the member rents the equipment, the carrier will make monthly payments only until it's share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first. Benefits for replacement or repair of purchased Durable Medical Equipment are subject to the carrier's approval. The carrier does not provide benefits for the repair or replacement of rented equipment. Supplies are covered if they are necessary for the proper functioning of the Durable Medical Equipment. If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for the disease or injury, benefits will be based on the least expensive method of treatment, device, or equipment that can meet the members need. | |
| Prostheses | Provide benefits for Prostheses, including artificial limbs and prosthetic appliances. | |
| Early Intervention Services | Provide benefits for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. The carrier may specify that a referral from the child's primary care provider is required. | |

| | | |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | <p>The policy or contract may limit coverage to the actuarial equivalent of at least \$3,200 worth of visits/services per year for each child not to exceed the actuarial equivalent of \$9,600 worth of visits/services by the child's 3rd birthday.</p> | |
| Emergency Room Care | Provide benefits for emergency room treatment received for medical emergencies. | |
| Foot Care | Provide benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered. | |
| Freestanding Imaging Centers | Provide benefits for Diagnostic Services performed by Freestanding Imaging Centers. Carrier may specify that all services must be ordered by a Provider. | |
| Hearing Care | <p>Provide benefits for wearable hearing aids for covered Members up to age 18. Coverage is limited to one hearing aid for each hearing-impaired ear every 36 months. The carrier may specify that related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.</p> <p>The policy or contract may limit coverage to the actuarial equivalent of at least \$1,400 per hearing aid for each hearing-impaired ear every 36 months.</p> | |
| Home Health Care Services | <p>Provide benefits for home health care services when services are performed and billed by a home health care agency. The carrier may specify that a home health care agency must submit a written plan of care, and then provide the services as approved by the carrier.</p> <p>Must provide not less than 90 visits in any continuous period of 12 months.</p> | |
| Hospice Care Services | <p>Provide benefits for Hospice Care services furnished by a Home Health Agency to a Member who is terminally ill and the Member's family. A Member who is terminally ill means a person who has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course.</p> <p>Provide benefits for Hospice Care services by a Home Health Agency up</p> | |

| | | |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | <p>to 24 hours during each day of care. The carrier may specify that Hospice Care services are provided according to a written care delivery plan developed by a Hospice Care Provider and the recipient of Hospice Care services. Prior approval may be required. Coverage for Hospice Care services is provided in either a home or Inpatient setting.</p> <p>Hospice Care services include, but are not limited to: Physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and Durable Medical Equipment, occupational, physical or speech therapies, home health care services, bereavement services, and volunteer services.</p> | |
| Hospice Respite Care | <p>Provide benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide Hospice Care.</p> <p>The carrier may specify that before the patient receives respite care at home, a Home Health Agency must submit a plan of care for approval.</p> | |
| Inpatient Hospice Services | <p>Provide benefits for Inpatient Hospice Care at an acute care Hospital or Skilled Nursing Facility. The same services are covered for Inpatient Hospice Care as are covered under the 'Inpatient Hospital Services' provision.</p> | |
| Inborn Errors of Metabolism | <p>Provide benefits for metabolic formula and special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by Inborn Error(s) of Metabolism. This benefit is limited to those Members with diseases caused by Inborn Error(s) of Metabolism.</p> <p>Must provide coverage for metabolic formula and up to the actuarial equivalent of at least \$3,000 worth of prescribed modified low-protein products per year.</p> | |
| Independent Laboratories | <p>Provide benefits for Diagnostic Services performed by independent laboratories. The carrier may specify that all services must be ordered by a Provider.</p> | |
| Infant Formula | <p>Provide benefits for amino acid-based elemental infant formula for children 2 years of age and under. The carrier may specify that benefits</p> | |

| | | |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | <p>are provided when a provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. The carrier may specify that a provider may be required to confirm and document ongoing medical necessity at least annually.</p> <p>Benefits for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula.</p> <p>Benefits are provided when a covered Provider has diagnosed and through medical evaluation has documented one of the following conditions: symptomatic allergic colitis or proctitis; laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis; a history of anaphylaxis; gastroesophageal reflux disease that is nonresponsive to standard medical therapies; severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; cystic fibrosis; or malabsorption of cow milk-based or soy milk-based infant formula.</p> | |
| Infusion Therapy | <p>Provide benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.</p> | |
| Inhalation Therapy | <p>Provide benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.</p> | |
| Inpatient Hospital Services | <p>Provide benefits for the following Inpatient Hospital services: room and board, including general nursing care, special duty nursing, and special diets, in a semiprivate room or a private room when medically necessary or when the facility offers only private rooms; use of intensive care or coronary care unit; diagnostic services; medical, surgical, and central supplies; treatment services; hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services; Phase I Cardiac Rehabilitation; medication used when the member is an inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for</p> | |

| | | |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | <p>purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the carrier for medically accepted indications or as required by law; blood and blood derivatives; prostheses or orthotic devices; newborn care, including routine well-baby care.</p> | |
| Massage Therapy | <p>Provide benefits for massage therapy when services are part of an active course of treatment and the services are performed by a covered provider. A massage therapist is not a covered provider.</p> | |
| Medical Care | <p>Provide benefits for medical care and services including office visits and consultations, Hospital and Skilled Nursing Facility visits, and pediatric services.</p> | |
| Medical Supplies | <p>Provide benefits for medical supplies furnished by a Provider in the course of delivering medically necessary services. The carrier may specify that this benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a Physician.</p> | |
| Mental Health and Substance Abuse Services | <p>Provide benefits for only the following Mental Health and Substance Abuse services when they are for the active treatment of Mental Health and Substance Abuse disorders. The carrier may specify that these services must be part of an established plan of treatment and must be performed and independently billed by a Provider acting within the scope of his or her license.</p> <p>Benefits for Inpatient, Outpatient, and day treatment services for Mental Health and Substance Abuse are provided when the member receive them from a Provider. Covered Services include the following: Inpatient Services in a Hospital or any Facility that the carrier must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification. Outpatient Services including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs. Residential Treatment, specialized 24-hour treatment in a licensed Residential Treatment Center, offering individualized and intensive treatment including: observation and assessment by a psychiatrist weekly or more often, rehabilitation,</p> | |

| | | |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | therapy, and education. | |
| Morbid Obesity | Provide limited benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. The carrier may specify that benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. | |
| Nutritional Counseling | Provide benefits for nutritional counseling when required for a diagnosed medical condition. | |
| Obstetrical Services and Newborn Care | Provide benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. | |
| Office Visits | Provide benefits for office visits. Office visits include visits to a retail health clinic. Services at a retail health clinic are limited to basic health care services to Members on a ‘walk-in’ basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by physician’s assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children. | |
| Online Visits | <p>When available in the member’s area, coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice.</p> <p>Non Covered Services include, but are not limited to, communications used for: reporting normal lab or other test results, office appointment requests, billing, insurance coverage or payment questions, requests for referrals to doctors outside the online care panel, benefit precertification, physician to physician consultation</p> <p>Please refer to the “Telemedicine” provisions for additional or different services available.</p> | |
| Organ and Tissue Transplants | Provide benefits for organ and tissue transplant procedures listed below. The carrier may specify that the member must receive prior approval before he/she is admitted for any transplant procedure. Transplants include: heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow. | |
| Human leukocyte antigen testing/Cost of testing for bone marrow donation | Provide coverage for laboratory fees up to \$150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements: | |

| | | |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>suitability</p> | <p>A. The Member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;</p> <p>B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;</p> <p>C. At the time of the testing, the Member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.</p> <p>This benefit is limited to one test per lifetime.</p> | |
| <p>Orthotic Devices</p> | <p>Provide benefits for certain Orthotic Devices, such as orthopedic braces, back or surgical corsets, and splints. The carrier may specify that they do not provide benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.</p> | |
| <p>Outpatient Services</p> | <p>Provide benefits for the following Hospital Outpatient and Rural Health Center services: Emergency room services/emergency care; removal of sutures; application or removal of a cast; diagnostic services; surgical services; removal of impacted or unerupted teeth; endoscopic procedures; blood administration; radiation therapy; outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. The carrier may specify that benefits for these services have special requirements.</p> <p>Must provide at least 20 visits per year for physical and occupational therapy combined and 20 for speech therapy.</p> <p>Must provide at least 36 visits per cardiac episode.</p> | |
| <p>Parenteral and Enteral</p> | <p>Provide benefits for parenteral and enteral therapy, including supplies</p> | |

| | | |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Therapy | and equipment needed to appropriately administer parenteral and enteral therapy. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy. | |
| Physical and Occupational Therapy | Provide benefits for short-term physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. Carrier may specify that services are covered only when provided by a licensed Provider acting within the scope of his/her license. Carrier may specify that no benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. Must provide at least 20 visits per year for physical and occupational therapy combined. | |
| Prescription Drugs | Provide benefits under the member's prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a Hospital. | |
| Preventive and Well-Care Services | Provide benefits for preventive care services that meet the requirements of Federal and State law, including certain screenings, immunizations and physician visits. | |
| Radiation Therapy | Provide benefits for Radiation Therapy. | |
| Reconstructive Surgeries, Procedures and Services | Provide benefits for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. The carrier may specify that reconstructive surgeries, procedures and services must be: 1. necessary due to accidental injury; or 2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or 3. Medically Necessary Health Care to restore or improve a bodily function, or 4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. (Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate) or 5. reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance. | |
| Skilled Nursing Facility Services | Provide benefits for Inpatient Skilled Nursing Facility services. | |

| | | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | Must provide at least 150 days per year. | |
| Smoking Cessation | Provide benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. NRT products can include but are not limited to: nicotine patches, gum, or nasal spray. The carrier may specify that these products and medications must be prescribed by the member's Physician. Provide benefits for follow-up smoking cessation education and counseling. Provide benefits for completing an approved smoking cessation program. | |
| Speech Therapy | Provide benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Carrier may specify that services are covered only when provided by a licensed Provider acting within the scope of his/her license. Must provide at least 20 visits per year for speech therapy. | |
| Surgical Services | Provide benefits for surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care. | |
| Telemedicine | Provide benefits for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care Provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation. | |