Benefits for Health Care Coverage

Alaska Benchmark Pan

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I. At a Glance – Covered and Not Covered

Disclaimer:

The following Alaska Essential Health Benefits (EHB) Benchmark Plan is provided as a summary of covered services and supplies in major medical health insurance coverage in Alaska beginning in Plan Year 2026. This EHB Benchmark Plan is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not.

Nothing in this 2026 Benchmark plan should be construed as additional EHB requirements under Federal Law. At no time shall the set of benefits listed below be construed to allow an issuer to NOT cover any and all federal and state required benefits.

To the extent that the Benchmark Plan does not comply with federal requirements, including the mental health parity and addiction equity act (MHPAEA), individual and small group market carriers must conform benefits to meet all applicable federal and state requirements when designing plans that are substantially equal to the Benchmark Plan. This includes ensuring that the availability of benefits is not discriminatory under state and federal law.

II. WHAT ARE MY MEDICAL BENEFITS?

ACUPUNCTURE

Benefits are provided for acupuncture services up to a maximum of 12 visits per member each calendar year. Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition.

AIR OR SURFACE TRANSPORTATION

This benefit is limited to only those services that are for a sudden, life-endangering illness or injury that results in your hospital admission at the end of the transport. Benefits are provided for one-way air or surface transportation, for you only, by a licensed commercial carrier. The trip must begin at the location in Alaska where you became ill or injured and end at the location of the nearest hospital equipped to provide treatment not available in a local facility.

This Air or Surface Transportation benefit doesn't cover:

- Services that aren't sudden and life-endangering
- Transport by taxi, bus, private car or rental car
- Meals and lodging

AMBULANCE SERVICES

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the member that requires transportation. Benefits for ambulance transport depend on whether the medical condition is a medical emergency (see "Definitions").

Medical Emergency Transport
Covered in the case of a medical emergency.

Non-Emergent Transport
For a medically non-emergent condition, this benefit covers surface transport (ground or water) received from a licensed ambulance.

Air Transport
Covered as medically necessary and in accordance with plan specifications.

AMBULATORY SURGICAL CENTER SERVICES
Benefits are provided for services and supplies furnished by a licensed ambulatory surgical center.

AUTISM SPECTRUM DISORDER SERVICES
This benefit covers medically necessary services and supplies for members for the diagnosis and treatment of autism spectrum disorders.

Coverage is provided for the following:

- Habilitative or rehabilitative care, including applied behavior analysis, counseling and treatment programs necessary to develop, maintain, or restore the functioning of an individual
- Psychiatric and psychological care. Covered services include inpatient care and outpatient therapeutic visits.
- Therapeutic care as identified in a treatment plan developed following a comprehensive evaluation, including behavioral, speech, occupational, and physical therapies
-

Treatment may be provided by the following providers:

- A licensed physician
- A psychologist
- An advanced nurse practitioner
- An autism service provider (see “Definitions”) or a provider supervised by an autism service provider

Any other provider type that is licensed to practice where the care is provided, is providing a service within the scope of that license
Medically Necessary
For the purposes of this benefit, “Medically Necessary” is defined as care, treatment, intervention, service, or item prescribed by a licensed physician, psychologist, or advanced nurse practitioner in accordance with accepted standards of practice that will, or is reasonably expected to:

- Prevent the onset of an illness, condition, injury or disability
- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability
- Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacity of other person of the individual’s age

BLOOD PRODUCTS AND SERVICES
Benefits are provided for the cost of blood and blood derivatives.

CANCER CLINICAL TRIALS

Benefits for routine medical care in an approved cancer clinical trial, including leukemia, lymphoma and bone marrow stem cell disorders are included when your treating physician has determined:

- There is no superior non-investigational treatment alternative; and
- When available clinical or preclinical data provide a reasonable expectation that the treatment provided in the cancer clinical trial will be at least as effective as any non-investigational alternative.

Benefits for covered services are provided based on the type of services received as shown in the "What Are My Medical Benefits?" section. For example, benefits for inpatient care in a hospital are provided as shown under Hospital Inpatient Care; benefits for office visits are provided as shown under the Professional Visits and Services benefits; and benefits for lab and imaging are provided as shown under the Diagnostic Services benefits.

Routine Medical Care

Benefits for routine medical care that would otherwise be covered under this plan if the medical care were not in connection with an approved cancer clinical trial are provided as stated above and include the following:

- Prevention, diagnosis, treatment, and palliative care of cancer
- Items or services necessary to provide an investigational item or service
- Diagnosis and treatment of complications
- A drug or device approved by the FDA whether or not the FDA approved the drug or device for use in treating a particular condition and only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device
- Services necessary to administer a drug or device under evaluation in the cancer clinical trial

Transportation Expenses

Covered services are limited as follows:

- Transportation provided for the member enrolled in the approved cancer clinical trial and one companion
- Transportation primarily for and essential to the medical care
- Transportation to and from the site of usual treatment to the site of the clinical trial
- Commercial coach fare for air transportation
- Transportation for follow-up care following the initial treatment when the follow-up care cannot be provided where the member resides

This Cancer Clinical Trial's benefit doesn't cover the following:

- Clinical trials that are not related to cancer
- Clinical trials that are not an approved clinical trial as described in the "Definitions" section in this booklet
- A drug or device associated with the approved clinical trial that has not been approved by the FDA
- Housing, meals, or other nonclinical expenses
- Companion expenses, except for transportation as described under covered services
- Items or services provided solely to satisfy data collection and analysis and not used in the clinical management of the patient
- An item or service excluded from coverage under this plan
- An item or service paid for or customarily paid for through grants or other funding

CONTRACEPTIVE MANAGEMENT AND STERILIZATION

This benefit covers the following services and supplies:

- Office visits and consultations related to contraception
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility charges will be subject to your cost-shares under the applicable facility benefit and are not covered by this benefit.
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)

PRESCRIPTION CONTRACEPTIVES DISPENSED BY A PHARMACY

Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies are covered when dispensed by a licensed pharmacy. Examples of covered devices are diaphragms and cervical caps.

This Contraceptive Management and Sterilization benefit doesn't cover the following:

- Hysterectomy. (Covered on the same basis as other surgeries. See the Surgical Services benefit.)
- Non-prescription contraceptive drugs, supplies or devices (except emergency contraceptive methods)
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

DENTAL SERVICES

The medical benefits of this plan will only be provided for the dental services listed below.

Accidental Injuries

When services are related to an accidental injury, benefits are provided for the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the accidental injury. These services are only covered when they're:

- Necessary as a result of an accidental injury;
- Performed within the scope of the provider's license;
- Not required due to damage from biting or chewing; and
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
- Extensive restoration, veneers, crowns or splints
- Periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury

Please Note: An accidental injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

Benefits for hospital or ambulatory surgical center care for dental procedures aren't provided, except for general anesthesia and related facility services that are medically necessary for one of two reasons:

- The member has a dental condition that can't be safely and effectively treated in a dental office; or

- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center.

Please Note: This benefit won't cover the dentist's services unless the services are to treat a dental accident and meet the requirements described above.

DIAGNOSTIC SERVICES

Preventive diagnostic services are laboratory and imaging services that meet the federal guidelines for preventive care services stated in the Preventive Care benefit.

Diagnostic surgeries, including scope insertion procedures, such as endoscopies, can only be covered under the Surgical Services benefit.

Benefits are provided for diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Diagnostic imaging and scans (including x-rays and EKGs)
- Laboratory services, including routine and preventive
- Pathology tests
- Cancer screening tests, to include at a minimum:
- Annual tests for prostate cancer as recommended by a physician based on medical best practices.
- Annual cervical cancer pap smears as recommended by a physician based on medical best practices.
- Screening tests for colorectal cancer as recommended by a physician based on medical best practices.

Please Note: When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit. When covered outpatient diagnostic services are furnished and billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the Hospital Outpatient or Emergency Room Care benefits.

This Diagnostic Services benefit doesn't cover:

- Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy. These services can only be covered under the Surgical Services benefit.
- Allergy testing. See the Professional Visits and Services benefit for coverage of allergy testing.
- Covered inpatient diagnostic services that are furnished and billed by an inpatient facility. These services are only eligible for coverage under the applicable inpatient facility benefit.
- Covered outpatient diagnostic services that are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services. Benefits are provided under the Hospital Outpatient or Emergency Room Care benefits.
- Services related to the testing, diagnosis or treatment of infertility
- Mammography services. Please see the Mammography Services benefit.

EMERGENCY ROOM CARE

This benefit is provided for emergency room facility services including procedure, operating, and recovery rooms; plus services and supplies such as surgical dressings and drugs furnished by and used while at

the emergency room. Additionally, when covered outpatient diagnostic services are furnished and billed by an emergency room and received in combination with other emergency room services, benefits are provided under this benefit.

HEALTH MANAGEMENT

Health Education

Benefits are provided for outpatient health education services to manage a covered condition, illness or injury. Examples of covered health education services are diabetes health education, asthma education, pain management, and childbirth and newborn parenting training.

Nicotine Dependency Programs

Benefits are provided for outpatient nicotine dependency programs.

This Health Management benefit doesn't cover drugs for the treatment of nicotine dependency. Please see the "What Are My Prescription Drug Benefits?" section.

HEARING AIDS & EXAMS

This benefit provides coverage for hearing aids – up to one hearing aid per ear every three years and an annual exam. To be covered, benefits must be provided for hearing services or items by an audiologist, otologist, otolaryngologist, or a physician. The provider must certify that these services and items are medically necessary to alleviate a disability caused by hearing impairment and are the least costly alternative that fits the recipient's medical need.

Health plans may limit coverage of hearing aids to one hearing aid per ear, per recipient, per three calendar years.

This Hearing Aids and Exams benefit does not cover hearing aid supplies included with a hearing aid, including a single cord, a y-cord, a harness, a new receiver, or a bone-conduction receiver with headband.

HOME AND HOSPICE CARE

To be covered, home health and hospice care must be part of a written plan of care prescribed, periodically reviewed and approved by a physician. In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without home health or hospice services.
Benefits are provided, up to the following maximums, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Home Health Care

This benefit provides up to 130 intermittent home visits per member each calendar year by a home health care provider. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit.

Hospice Care

Benefits for a terminally ill member shall not exceed 6 months of covered hospice care. Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under "Home Health

Care."

- **Inpatient hospice care** up to a maximum of 10 days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice.

This Home and Hospice Care benefit doesn't cover any of the following:

- Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements
- Drugs and solutions received while you're an inpatient, except for covered inpatient hospice care
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

HOSPITAL INPATIENT CARE

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives and their administration

Please Note: For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

This Hospital Inpatient Care benefit doesn't cover any of the following:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition

HOSPITAL OUTPATIENT CARE

This benefit covers operating rooms, procedure rooms and recovery rooms. Also covered are services and supplies, such as surgical dressings and drugs, furnished by and used while at the hospital. Additionally, when covered outpatient diagnostic services are furnished and billed by an outpatient facility and received in combination with other outpatient hospital services, benefits are provided under this benefit.

INFUSION THERAPY

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

This Infusion Therapy benefit doesn't cover any of the following:

- Charges in excess of the average wholesale price shown in the Pharmacist's Red Book for drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements
- Drugs and solutions received while you're an inpatient in a hospital or other medical facility

MAMMOGRAPHY SERVICES

Preventive mammography services include a baseline mammogram and annual mammogram screenings thereafter, regardless of age. Benefits are also provided for mammography for a member with symptoms, a history of breast cancer, or whose parent or sibling has a history of breast cancer, or as recommended by a physician.

MASSAGE THERAPY

Benefits for the manipulation and treatment of the soft tissues to enhance the functions of those tissues are provided up to a combined maximum benefit of 20 visits per member each calendar year. Services must be part of a physical therapy treatment plan or otherwise medically necessary to treat a covered illness, injury or condition and provided by a physician, massage therapist or other provider.

MASTECTOMY AND BREAST RECONSTRUCTION SERVICES

Benefits are provided for mastectomy necessary due to disease, illness or accidental injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of all stages of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

MEDICAL EQUIPMENT AND SUPPLIES

Benefits are provided for the following covered medical equipment, prosthetics, orthotics and supplies (including sales tax for covered items):

Medical and Respiratory Equipment

Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical Supplies, Orthotics (Other Than Foot Orthotics), and Orthopedic Appliances

Covered items include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

Prosthetics

Benefits for external prosthetic devices (including fitting expenses) are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

Medical Vision Hardware

Benefits are provided for vision hardware for medical conditions of the eye as medically necessary. For example, qualifying conditions may include but are not limited to: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjorgren's disease, congenital cataract, corneal abrasion, and keratoconus.

Breast Pumps

This benefit covers the purchase of standard electric breast pumps. Rental of hospital-grade breast pumps is also covered when medically necessary. Purchase of hospital-grade pumps is not covered.

For further information, please see the Preventive Care benefit.

Please Note: When covered inpatient medical supplies and equipment are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit.

Medical Equipment and Supplies benefit doesn't cover any of the following:

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses

- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home and/or personal vehicle
- Eyeglasses, contact lenses and other vision hardware for conditions not listed as a covered medical condition, including routine eye care
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self- administered medications, except as specified in the "What Are My Prescription Drug Benefits?" section.

NEURODEVELOPMENTAL THERAPY

Benefits are provided for the treatment of neurodevelopmental disabilities for members as medically necessary. The following inpatient and outpatient neurodevelopmental therapy services must be medically necessary to restore and improve function, or to maintain function where significant physical deterioration would occur without the therapy.

- **Inpatient Care Benefits** for inpatient facility and professional care are provided up to 30 days per member each calendar year. Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility, and will only be covered when services can't be done in a less intensive setting.
- **Outpatient Care Benefits** for outpatient care are subject to the following provisions:
  - The member mustn't be confined in a hospital or other medical facility.
  - The therapy must be part of a formal written treatment plan prescribed by a physician.
  - Services must be furnished and billed by a hospital, rehabilitation facility, physician, physical, occupational or speech therapist.

When the above criteria are met, benefits will be provided for physical, speech, and occupational therapy services, up to a maximum benefit of 45 visits per member each calendar year. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Please Note: Inpatient care and outpatient therapeutic care for autism spectrum disorders related treatment for members under the age of 21 are not subject to the above noted benefit maximums.

This benefit won't be provided with the Rehabilitation Therapy and Chronic Pain Care benefit for the same condition.

This Neurodevelopmental Therapy benefit doesn't cover the following:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care

NEWBORN CARE

Benefits for routine hospital nursery charges and related inpatient well-baby care for a newborn dependent child or newborn dependent grandchild are provided up to:

- 48 hours after a normal vaginal birth; or
- 96 hours after a normal cesarean birth

Benefits are also provided for routine circumcision.

NEWBORN HEARING EXAMS AND TESTING

This benefit provides for one screening hearing exam for newborns up to 30 days after birth.

Benefits are also provided for diagnostic hearing tests, including administration and interpretation, for children up to age 24 months if the newborn hearing screening exam indicates a hearing impairment.

NUTRITIONAL THERAPY

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury, including services to manage diabetes or eating disorders. Nutritional therapy services that meet the federal guidelines designated as preventive care will be subject to applicable frequency limits. Nutritional therapy visits provided as medically necessary have no visit limit.

Weight Loss Benefits & Drugs

Outpatient nutritional care services including weight management nutritional care are covered as medically necessary. Covered Services include assessment of food practices and dietary/nutritional status and diet counseling for preventive and therapeutic needs for the diagnosed medical conditions. Coverage shall also be provided for the use of GLP1 and GIP drugs (which can include drugs such as semaglutide) as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity. Please see the Prescription Drug section for more information.

OBSTETRICAL CARE

Benefits for pregnancy, childbirth and voluntary termination of pregnancy are provided on the same basis as any other condition for all female members.

Certain preventive diagnostic obstetrical services that meet the preventive federal guidelines as defined for women’s health are covered as stated in the Preventive Care benefit when you see a network provider.

Please see the Surgical Services benefit for details on surgery coverage.

Obstetrical care benefits cover the following:

Benefits for the hospital stay and related inpatient medical care following childbirth are provided up to:

- 48 hours after a normal vaginal birth; or
- 96 hours after a normal cesarean birth

Plan benefits are also provided for medically necessary services and supplies related to home births and birthing centers.

PHENYLKETONURIA (PKU) DEITARY FORMULA

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU).

PREVENTIVE CARE

What Are Preventive Services?

Preventive services are defined as follows:

- Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Also included are additional preventive care and screenings for women not described in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Services designated as preventive care when they meet the federal guidelines include periodic exams, routine immunizations described below and laboratory and imaging services that are covered as preventive under the Diagnostic Services benefit or the Mammography benefits.

The following exam services are covered as long as they fall within the federal guidelines above in this benefit:

- Routine physical exams
- Well-baby exams and well-child exams, including those provided by a qualified health aide
- Physical exams related to school, sports, and employment

Women's Preventive Care

Examples of covered women's preventive care services include, but are not limited to:

- Contraceptive counseling
- Breast feeding counseling
- Maternity diagnostic screening
- Screening for gestational diabetes
- Counseling for sexually transmitted infections

Please see the Medical Equipment and Supplies benefit for details on breast pump coverage. Please also see the Contraceptive Management and Sterilization, Diagnostic Services, Health Management, and Obstetrical Care benefits for further detail.

This Preventive Care benefit doesn't cover any of the following:

- Charges for services or items that don't meet the federal guidelines for preventive services described at the beginning of this benefit, except as required by law. This includes services or items provided more often than as stated in the guidelines.
- Inpatient newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.

- Services not named above as covered
- Routine or other dental care
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member. Please see the plan's non-preventive benefits for available coverage.
- Physical exams for basic life or disability insurance
- Work-related or medical disability evaluations
- Routine vision exams

PROFESSIONAL VISITS AND SERVICES

The Professional Visits and Services benefit covers the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home.

Benefits are also available for the following professional services:

- Allergy testing
- Second opinions for any covered medical diagnosis or treatment plan when provided by a qualified provider
- Prostate, colorectal, and cervical cancer screening exams, unless they meet the guidelines for preventive medical services described in the Preventive Care benefit.
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see "Definitions") when provided by a qualified provider
- Routine foot care as medically necessary
- Therapeutic injections, including allergy injections
- Consultations and treatment for nicotine dependency

Telehealth

Coverage for visits throughout this plan includes real-time visits using online and telephonic methods with your doctor or other provider (telemedicine) when appropriate. Coverage is for services by a provider licensed in the location where the member is located. No prior in-person contact is necessary.

This Professional Visits and Services benefit doesn’t cover the following:

- Surgical procedures performed in a provider’s office, surgical suite or other facility. These services are covered under the Surgical Services benefit, unless they meet the guidelines for preventive medical services described in the Preventive Care benefit.
- Professional diagnostic and laboratory services. These services are covered under the Diagnostic Services benefit, unless they meet the guidelines for preventive medical services described in the Preventive Care benefit.
- Home health or hospice care visits. These services are covered under the Home and Hospice Care benefit.
- Hair analysis or non-legend drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services
- Services related to the diagnosis and treatment of temporomandibular joint disorder
- Services related to the diagnosis or treatment of psychiatric conditions, including biofeedback services

- Contraceptive injections or implantable contraceptives. These services are covered under the Contraceptive Management and Sterilization benefit.

PSYCHOLOGIAL AND NEUROPSYCHOLOGICAL TESTING

Benefits are provided up to a maximum benefit of 12 hours per member each calendar year for all services combined.

Please Note: This benefit maximum does not apply to autism spectrum disorders related testing and services.

Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the Rehabilitation Therapy and Chronic Pain Care benefit.

See the Neurodevelopmental Therapy benefit for physical, speech or occupational therapy assessments and evaluations related to neurodevelopmental disabilities.

REHABILITATION THERAPY AND CHRONIC PAIN CARE

Rehabilitation Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Please see the Neurodevelopmental Therapy benefit earlier in this section for coverage of disorders caused by neurological congenital anomalies.

Inpatient Care Benefits for inpatient facility and professional care are available up to 30 days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility, and will only be covered when services can't be done in a less intensive setting.

When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

Outpatient Care Benefits for outpatient care are subject to the following provisions:

- You mustn't be confined in a hospital or other medical facility
- The therapy must be part of a formal written treatment plan prescribed by a physician
- Services must be furnished and billed by a hospital, rehabilitation facility, physician, physical, occupational, or speech therapist

When the above criteria are met, benefits will be provided for physical, speech and occupational therapy services, including cardiac and pulmonary rehabilitation, up to a maximum benefit of 45 visits per member each calendar year. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Please Note: Inpatient care and outpatient care for autism spectrum disorders related treatment are not subject to the above noted benefit maximums.

Chronic Pain Care

These services must also be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits.

This benefit won't be provided in addition to the Neurodevelopmental Therapy benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available for the same condition under the other.

This Rehabilitation Therapy and Chronic Pain Care benefit doesn't cover the following:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made the rehabilitation services necessary

SKILLIED NURSING FACILITIES

Benefits are provided up to 60 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a skilled nursing facility.

SPINAL AND OTHER MANIPULATIONS

Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 20 visits per member each calendar year. Services must be medically necessary to treat a covered illness, injury or condition.

If covered outpatient rehabilitation therapy services are received, they are only eligible for coverage under the Rehabilitation Therapy benefit.

SURGICAL SERVICES

This benefit covers surgical services including anesthesia, postoperative care, cornea transplantation, skin grafts and the transfusion of blood or blood derivatives. Colonoscopy and other scope insertion procedures are also covered under this benefit unless they meet the guidelines for preventive services described in the Preventive Care benefit. Please see the Diagnostic Services benefit for coverage of preventive diagnostic services.

For organ, bone marrow or stem cell transplant procedure benefit information, please see the Transplants benefit.

TRANSPLANTS

This benefit covers medical services only if provided by "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Covered Transplants

Solid organ transplants and bone marrow/stem cell reinfusion procedures mustn't be considered experimental or investigational for the treatment of your condition. (Please see the "Definitions" section in this booklet for the definition of "experimental/ investigational services".) We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must be medically necessary and meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition and failure of medical alternatives.

  The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:

  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney
  - Pancreas
  - Pancreas with kidney
  - Bone marrow (autologous and allogeneic)
  - Stem cell (autologous and allogeneic)

Please Note: For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). Benefits for such services are provided under other benefits of this plan.

Recipient Costs

This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs

Procurement expenses and covered donor costs are provided as medically necessary and as approved by the plan. Covered donor services may include but are not limited to selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation and Lodging Expenses

Reasonable and necessary expenses for transportation, lodging and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:
The transplant recipient must reside more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require the member to remain closer to the transplant center.
The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post- discharge follow-up.
When the recipient is a dependent minor child, reasonable benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided.
When the recipient isn't a dependent minor child, reasonable benefits for transportation, lodging and meal expenses for the recipient and 1 companion will be provided.

This Transplants benefit doesn't cover the following:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless they aren't "experimental or investigational services" (please see the "Definitions" section in this booklet)
- Personal care items
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future
- Take-home prescription drugs dispensed by a licensed pharmacy. See the "What Are My Prescription Drug Benefits?" section for benefit information.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

The following inpatient and outpatient services for TMJ may be covered if they are deemed medically necessary: diagnostic x-rays; lab testing; physical therapy; and surgery.

III. WHAT ARE MY PRESCRIPTION DRUG BENEFITS?

This benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits, allergy emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered in this benefit are injectable supplies. Generic alternatives are FDA-approved as safe and effective as brand name drugs but are more cost effective.

Additionally, coverage will not be provided for prescribed drugs that have ample availability/variety of over-the-counter comparables. These contain drugs included in, but not limited to, therapeutic classes for heartburn, allergy, and cough/cold remedies. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of- pocket expense exceed the cost of the drug or supply.

What's Covered?

This benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit covers off-label use of FDA-approved drugs as provided under this plan's definition of "Prescription Drug" (please see the "Definitions" section in this booklet).
- Prescriptive oral agents for controlling blood sugar levels
- Prescribed injectable medications for self- administration (such as insulin)
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms, patches and cervical caps). See the Contraceptive Management and Sterilization benefit for additional detail.
- Compounded medications of which at least one ingredient is a covered prescription drug

- Inhalation spacer devices and peak flow meters
- Prescription drugs for the treatment of autism
- Glucagon and allergy emergency kits
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a retail participating pharmacy. Over the counter nicotine products are subject to the generic drug cost- share. Your normal cost-share for drugs received from a participating pharmacy is waived for certain prescription nicotine dependency drugs that meet the guidelines for preventive services described in the Preventive Care benefit.
- Weight management drugs as medically necessary

For benefit information concerning therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit), please see the Medical Equipment and Supplies benefit.

Benefits for immunization agents and vaccines, including the professional services to administer them, are provided under the Preventive Care benefit.

IV. WHAT'S NOT COVERED?

This section of your booklet explains circumstances in which all the benefits of this plan are either limited or no benefits are provided. Benefits can also be affected by your eligibility. In addition, some benefits have their own specific limitations.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, benefits aren't available for the following:

Biofeedback Services

- EEG biofeedback, neurofeedback, or biofeedback services for psychiatric conditions

Caffeine Dependency

Treatment of caffeine dependency, except for services covered under the Health Management benefit.

Charges In Excess Of The Average Wholesale Price For Drugs

Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions, as specified in the Home and Hospice Care and Infusion Therapy benefits.

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Clinical Trials

- Clinical trials that are not related to cancer
- Clinical trials that are not an approved clinical trial as described under Cancer Clinical Trials
- A drug or device associated with the approved clinical trial that has not been approved by the FDA
- Housing, meals, or other nonclinical expenses

- Companion expenses, except for transportation as described under Cancer Clinical Trials
- Items or services provided solely to satisfy data collection and analysis and not used in the clinical management of the patient
- An item or service excluded from coverage under this plan
- An item or service paid for or customarily paid for through grants or other funding

Cosmetic Services

Services and supplies (including drugs) rendered for cosmetic purposes and plastic surgery, whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance, shape of a body structure, including any direct or indirect complications and aftereffects thereof.

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
- Repair of a dependent child's congenital anomaly
- Reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit
- Correction of functional disorders (not including removal of excess skin and or fat related to weight loss surgery or the use of obesity drugs), upon our review and approval

Counseling, Educational Or Training Services

- Counseling, education or training services, except as stated under the Health Management and Nutritional Therapy benefits. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling; and family and marital psychotherapy.
- Community wellness classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child, and infant CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety and parenting skills
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities in children under the age of 7 as stated under the Neurodevelopmental Therapy benefit or for members under the age of 21 who are diagnosed with autism spectrum disorder.
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy

Court-Ordered Services

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, unless such services are medically necessary**.**

Custodial Care

Custodial care, except when provided for hospice care (please see the Home and Hospice Care benefit).

Dental Care

Dental services or supplies, except services covered under the Dental Services benefit in the "What Are My Medical Benefits?" section.

Drugs And Food Supplements

Over-the-counter drugs (except as specifically stated), solutions, supplies, food and nutritional supplements, over-the-counter contraceptive drugs, supplies and devices, herbal, naturopathic, or homeopathic medicines or devices, hair analysis, and vitamins that don't require a prescription, except as required by law.

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental Or Investigational Services

Any service or supply that is determined to be experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. The determination is based on the criteria stated in the definition of "experimental/investigational services" (please see the "Definitions" section in this booklet).

Note: This exclusion does not apply to certain experimental or investigational services provided as part of an approved cancer clinical trial and as specified in the Cancer Clinical Trials benefit.

Family Members Or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father- in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse or grandparent or spouse of grandchild.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

Gender Transformations

Treatment or surgery to change gender, including any direct or indirect complications and after effects thereof.

Governmental Medical Facilities

Services and supplies furnished by a governmental medical facility, except when:

- You're receiving care for a "medical emergency" (please see the "Definitions" section in this booklet)
- We must provide available benefits for covered services as required by law or regulation

Hair Loss

- Hair prostheses, such as wigs or hair weaves, transplants, and implants
- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Prescription Drugs benefit, and are not covered to treat idiopathic short stature without growth hormone deficiency.

Infertility, Assisted Reproduction And Sterilization Reversal

- Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs

- Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof
- Reversal of surgical sterilization, including any direct or indirect complications thereof

Medical Equipment And Supplies

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids and telephone alert systems
- Structural modifications to your home and/or personal vehicle
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self- administered medications, except as specified in the "What Are My Prescription Drug Benefits?" section.

Military And War-Related Conditions, Including Illegal Acts

This includes:

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

No Charge Or You Don't Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, except as required by law in the case of federally qualified health center services

Not Covered Under This Plan

- Services or supplies ordered when this plan isn't in effect, or when the person isn't covered under this plan, except as stated under specific benefits and under Extended Benefits
- Services or supplies provided to someone other than the ill or injured member, other than outpatient health education services covered under the Health Education part of the Health Management benefit or donor costs under the Transplant benefit
- Services and supplies that aren't listed as covered under this plan
- Services and supplies directly related to any condition, or related to any other service or supply that isn't covered under this plan
- Charges for broken appointments

Not In The Written Plan Of Care

Services, supplies or providers not in the written plan of care or treatment plan in the Home and Hospice Benefit and Rehabilitation Therapy and Chronic Pain Care benefits.

Not Medically Necessary

- Services or supplies that aren't medically necessary, even if they're court-ordered. This also includes places of service, such as inpatient hospital care.
- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition

Obesity Services (Surgical)

Benefits are not provided for surgical treatments of obesity or morbid obesity, including surgery, and any direct or indirect complications, follow-up services, or after effects thereof; services and supplies connected with weight loss or weight control, except for health education classes or programs specified as covered under the Health Management benefit and for services covered under the Nutritional Therapy benefit and for assessments or counseling that meet the guidelines for preventive medical services in the Preventive Care benefit (An example of an after effect that would not be covered is removal of excess skin and or fat that developed as a result of weight loss surgery or the use of obesity drugs).This exclusion applies to all surgical obesity procedures (inpatient and outpatient), even if you also have an illness or injury that might be helped by weight loss.

Orthodontia Services

For orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

Orthognathic Surgery (Jaw Augmentation)

Procedures to lengthen or shorten the jaw (including orthognathic or maxillofacial surgery) aren't covered, regardless of the origin of the condition that makes the procedure necessary.

Outside The Scope Of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the jurisdiction in which the services or supplies were received.

Personal Comfort Or Convenience Items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges.
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home and Hospice Care benefit); and transportation services.
- Dietary assistance, such as "Meals on Wheels"

Private Duty Nursing Services

Private duty nursing.

Rehabilitation Services

Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery.

Routine Or Preventive Care

- Charges for services or items that don't meet the federal guidelines for preventive services described in the Preventive Care benefit, except as required by state and federal law. This includes services or items provided more often than stated in the guidelines.
- Routine or palliative foot care, including hygienic care
- Impression casting for foot prosthetics or appliances and prescriptions therefore, except as stated under the Professional Visits and Services benefit Fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. However, foot- support supplies, devices and shoes are covered as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability

Serious Adverse Events and Never Events

Members and this plan are not responsible for payment of services provided by network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes.

Network providers may not bill members for these services and members are held harmless.

- Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
- Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) Web page at www.cms.hhs.gov.

Services Covered By Other Sources

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other type of liability insurance coverage

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

Skilled Nursing Facility Coverage Exceptions

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency

Transplant Coverage Exceptions

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under the Transplants benefit

- Services or supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless they aren't "experimental or investigational services" (please see the "Definitions" section in this booklet)

Vision Exams

Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.

Vision Hardware

- Vision hardware (and fittings) used to improve visual sharpness, including eyeglasses and contact lenses and all related supplies
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light- sensitive lenses, even if prescribed

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment.

Work-Related Conditions

Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

- Occupational coverage required of, or voluntarily obtained by, the employer
- State or federal workers' compensation acts
- Any legislative act providing compensation for work-related illness or injury

However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

V. DEFINITIONS

The terms listed below have specific meanings under this plan.

Accidental Injury
Physical harm caused by a sudden and unforeseen event at a specific time and place. It's independent of illness, except for infection of a cut or wound.

Ambulatory Surgical Center
A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures
- It doesn't provide inpatient services or accommodations

Applied Behavior Analysis
The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

Autism Spectrum Disorders
Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the DSM of Mental Disorders-IV-TR, as amended or reissued from time to time.

Calendar Year
The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Cancer Clinical Trials
An approved cancer clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:
An institutional review board that complies with 45 CFR Part 46; and
One or more of the following:

- The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
- The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
- The United States Department of Defense
- The United States Department of Veterans' Affairs
- A nongovernmental research entity abiding by current National Institutes of Health guidelines

Congenital Anomaly
A marked difference, from the normal structure of a body part that's physically evident at birth.

Custodial Care
Any portion of a service, procedure or supply that is provided primarily:

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Experimental/Investigational Services
Experimental or Investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.

- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards set in the definition of "Cancer Clinical Trials" above in this section will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Group
A small employer, including a person, firm, corporation, partnership, or political subdivision, that is actively engaged in business and is a party to the Group Contract. The “Group” is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees.

Hospital
A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses
- A “hospital” will never be an institution that’s run mainly:
- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of substance use disorder or tuberculosis

Illness
A sickness, disease, medical condition, complications of pregnancy or pregnancy.

Inpatient
Confined in a medical facility as an overnight bed patient.

Massage Therapist
A state-licensed massage therapist.

Medical Equipment
Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or accidental injury. It’s of no use in the absence of illness or accidental injury.

Medical Emergency
The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy. (A “prudent layperson” is someone who has an average knowledge of health and medicine.) Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medical Facility (also called “Facility”)
A hospital, skilled nursing facility, or hospice.

Medically Necessary
Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" or "Your")
A person covered under this plan as an employee or dependent.

Network Provider
Providers that are in one of the networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Obstetrical Care
Care furnished during pregnancy (antepartum, delivery and postpartum), including voluntary termination of pregnancy, or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Orthotic
A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Outpatient
A patient receiving treatment in a setting other than as an inpatient in a medical facility.

Participating Pharmacy
A licensed pharmacy which contracts with us or the Pharmacy Benefits Administrator, to provide prescription drugs, as specified under the "What Are My Prescription Drug Benefits?" section.

Physician
A state-licensed:
- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy and Surgery (D.O.)
- Podiatrist (D.P.M.)

Professional services provided by one of the following types of providers will be covered under this plan but only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this plan, the benefit is medically necessary, and when benefits would be payable if the services were provided by a "Physician" as defined above:
- An Advanced Practice Registered Nurse (A.P.R.N.)
- A Certified Direct-Entry Midwife
- A Chiropractor (D.C.)
- A Dentist (D.D.S. or D.M.D.)
- A Dental Hygienist with an advance practice permit
- A Licensed Clinical Social Worker (L.C.S.W.)
- A Licensed Marital and Family Therapist (L.M.F.T.)

- A Licensed Marriage and Family Counselor (L.M.F.C.)
- A Licensed Professional Counselor
- A Naturopath (N.D.)
- A Nurse Midwife
- An Occupational Therapist (O.T.)
- An Optometrist (O.D.)
- A Pharmacist
- A Physical Therapist (P.T.)
- A Physician Assistant supervised by a collaborating M.D. or D.O.
- A Psychological Associate
- A Psychologist

Plan (also called "This Plan" or "The Plan")
The benefits, terms and limitations set forth in this booklet

Prescription Drug
Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
  - The American Hospital Formulary Service Drug Information;
  - The American Medical Association Drug Evaluation;
  - The United States Pharmacopoeia Drug Information; or
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner.
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts); or,
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Provider (also called "Covered Provider")
A physician or other health care professional or facility named in this plan that is licensed or certified as required by the state in which the services were received to provide a medical service or supply, and who does so within the lawful scope of that license or certification.

Psychiatric Condition
A condition listed in the **Diagnostic and Statistical Manual (DSM) IV** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

Skilled Nursing Facility
A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Temporomandibular Joint (TMJ) Disorders
TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Appendix A – Alaska State Mandates

Fully insured health plans must cover the following benefits and services:

Benefit Description	Citation
Maternity minimum stay	AS 21.42.347
Coverage for treatment of alcoholism or drug abuse	AS 21.42.365
Prostate and cervical cancer detection	AS 21.42.395
Colorectal cancer screening	AS 21.42.377
Mammograms	AS 21.42.375
Well Baby Exams	AS 21.42.351
Reconstructive surgery following mastectomy	AS 21.42.400
Clinical trials for cancer	AS 21.42.415
Diabetes	AS 21.42.390
Phenylketonuria	AS 21.42.380
Newborn and infant hearing screening	AS 21.42.349
Coverage for Autism Spectrum Disorders	AS 21.42.397
Coverage for prescription topical eye medication	AS 21.42.425
Acupuncture	AS 21.42.353
Congenital Anomaly of Child	AS 21.42.345
Emergency Room Care/Medical Emergencies	AS 21.07.020
Experimental and Investigational Services	AS 21.07.020
Obstetrical/Newborn Care	AS 21.42.347
Maternity coverage for dependents	AS 21.42.345, 347

Appendix B – Summary Benefits

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
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				Covered only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this plan, and when benefits would be payable if the services were provided by a physician.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Hospice Services	Yes	Covered	Yes	6	Month(s) per Lifetime	Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions, Over-the-counter drugs, solutions and nutritional supplements, Drugs and solutions received while you're an inpatient, except for covered inpatient hospice care, Services provided to someone other than the ill or injured member, Services of family members or volunteers, Services, supplies or providers not in the written plan of care or not named as covered in this benefit, Custodial care, except for hospice care services, Non-medical services, such as spiritual, bereavement, legal or financial counseling, Normal living expenses, such as food, clothing, and household supplies; housekeeping services except for those of a home health aide as prescribed by the plan of care; and transportation services, Dietary assistance, such as "meals on Wheels," or nutritional guidance.	Inpatient hospice care up to a maximum of 10 days. Respite care, up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.
Routine Dental Services (Adult)	No	Covered	No				
Infertility Treatment	No	Not Covered	No				
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	No	Not Covered	No				
Routine Eye Exam (Adult)	No	Covered	No				
Urgent Care Centers or Facilities	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Home Health Care Services	Yes	Covered	Yes	130	Visit(s) per Year	Services, supplies or providers not in the written plan of care or not named as covered benefit. Services provided to someone other than the ill or injured member. Custodial care, except for hospice care services. Non-medical services. Normal living expenses; and transportation services. Dietary assistance, such as "Meals on Wheels," or nutritional guidance.	130 visits per member each calendar year applies to home visits of a home health care provider or one or more: registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers; and a person with a master's degree in social work.
Emergency Room Services	Yes	Covered	No			Treatment of substance use disorder, except treatment of medically necessary detoxification services provided on same basis as any other emergency medical condition.	
Emergency Transportation/Ambulance	Yes	Covered	No			Air and Ground transportation: Services that aren't sudden and life-endangering, Transport by taxi, bus, private car or rental car, Meals and lodging.	Air and Ground transpiration benefit is limited to medical emergency. Ambulance services is separate benefit, covers both medical emergency transport and non-emergent transport.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless the medical condition makes inpatient care medically necessary. Any days of inpatient care that exceed the length of stay that is medically necessary to treat the condition.	
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	No	Not Covered	No				
Cosmetic Surgery	No	Not Covered	No				Exceptions to no coverage for cosmetic surgery: Repair of a defect that's the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident. Repair of a dependent child's congenital anomaly. Reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit. Correction of functional disorders (not including removal of excess skin and/or fat related to weight loss surgery or the use of obesity drugs), upon our review and approval.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Year		
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			Dementia and sleep disorders. Biofeedback services for psychiatric conditions other than generalized anxiety disorder. Family and marital counseling, and family and marital psychotherapy, except when medically necessary to treat the diagnosed psychiatric condition or conditions of a member. Therapeutic or group homes, foster homes, nursing homes, boarding homes or schools, military academies, and child welfare facilities. Telephonic services, except for crisis/emergency evaluations, or when the member is temporarily confined to bed for medical reasons. Telehealth services that do not utilize real-time video or audio services. Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders. Treatment of sexual dysfunctions, such as impotence. All medical services provided in preparation for or after gender reassignment surgery, also including the surgery medical counseling and hormone therapy, regardless of age.	
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential substance use disorder treatment. Residential detoxification.	
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary. Halfway houses, quarter way houses, recovery houses, and other sober living residences. Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential substance use disorder treatment. Residential detoxification.	
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Outpatient Rehabilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Recreational, vocational or educational therapy. Exercise or maintenance-level programs. Social or cultural therapy. Treatment that isn't actively engaged in by the ill, injured or impaired member. Gym or swim therapy. Custodial care. Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made the rehabilitation necessary.	A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the visit maximum. Multiple therapy sessions on the same day will be counted as 1 visit, unless provided by different health care providers.
Habilitation Services	Yes	Covered	Yes	45	Visit(s) per Year	Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof.	Habilitative services is only covered in the context of autism spectrum disorders services, including ABA, counseling and treatment programs necessary to develop, maintain, or restore the functioning of an individual.
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year		
Durable Medical Equipment	Yes	Covered	No			Supplies or equipment not primarily intended for medical use, Special or extra-cost convenience features, exercise equipment or weights, orthopedic appliances for use in sports, recreation or similar activities, penile prostheses, whirlpools, sauna baths, massage devices, structural modifications to home or vehicle.	
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years		1 per ear every 3 years

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No			Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy, Allergy Testing, Covered inpatient diagnostic services furnished and billed by inpatient facility, covered outpatient diagnostic services billed by outpatient facility or emergency room and received in combination with other hospital or emergency room services, services relating to testing, diagnosis, or treatment of infertility, mammography services.	
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	Yes	Covered	No				
Acupuncture	Yes	Covered	Yes	12	Visit(s) per Year		Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition.
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	45	Visit(s) per Year		Visit limit for physical, speech, and occupational therapy services combined.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	45	Visit(s) per Year		Visit limit for physical, speech, and occupational therapy services combined.
Well Baby Visits and Care	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	No				
Orthodontia - Child	Yes	Covered	No				
Major Dental Care - Child	Yes	Covered	No				
Basic Dental Care - Adult	No	Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No				
Transplant	Yes	Covered	No			Organ, bone marrow and stem cell transplants, including any direct or indirect complications and after effects thereof, except as specifically stated under the Transplants benefit. Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit. Non-human or mechanical organs, unless they aren't "experimental or investigational services." Transplants or related services from a provider not approved by us. Services that will be paid by any government foundation or charitable grant. This includes services performed on potential or actual living donors or recipients and on cadavers. Planned blood storage for more than 12 months for possible future use.	The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are: Heart, Heart/double lung, single lung, Double lung, Liver, Kidney, Pancreas, Pancreas with kidney, Bone marrow (autologous and allogenic), Stem cell (autologous and allogeneic).
Accidental Dental	Yes	Covered	No			Services must be completed within 12 months unless an extension is granted.	
Dialysis	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				
Radiation	Yes	Covered	No				
Diabetes Education	Yes	Covered	No				
Prosthetic Devices	Yes	Covered	No				Benefit limited to initial purchase of prosthetic; does not cover replacement unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.
Infusion Therapy	Yes	Covered	No			Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for drugs and solutions. Over-the-counter drugs, solutions and nutritional supplements. Drugs and solutions received while you're an inpatient in a hospital or other medical facility.	
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				
Nutritional Counseling	Yes	Covered	No			"Nutritional therapy services that meet the federal guidelines designated as preventive care will be subject to applicable frequency limits."	
Reconstructive Surgery	Yes	Covered	No				Breast reconstruction allowed.