

# **Benefits for Health Care Coverage**

## **Alaska Benchmark Plan**



# Table of Contents

<b>I. At a Glance – Covered and Not Covered</b> .....	<b>4</b>
<b>II. WHAT ARE MY MEDICAL BENEFITS?</b> .....	<b>4</b>
ACUPUNCTURE .....	4
AIR OR SURFACE TRANSPORTATION.....	4
AMBULANCE SERVICES .....	4
AMBULATORY SURGICAL CENTER SERVICES.....	5
AUTISM SPECTRUM DISORDER SERVICES .....	5
BLOOD PRODUCTS AND SERVICES.....	5
CLINICAL TRIALS.....	5
CONTRACEPTIVE MANAGEMENT AND STERILIZATION .....	6
PRESCRIPTION CONTRACEPTIVES DISPENSED BY A PHARMACY.....	7
DENTAL SERVICES .....	7
DIAGNOSTIC SERVICES .....	7
EMERGENCY ROOM CARE .....	8
HEALTH MANAGEMENT .....	8
HEARING AIDS & EXAMS .....	9
HOME AND HOSPICE CARE .....	9
HOSPITAL INPATIENT CARE .....	10
HOSPITAL OUTPATIENT CARE .....	10
INFUSION THERAPY .....	10
MAMMOGRAPHY SERVICES.....	11
MASSAGE THERAPY.....	11
MASTECTOMY AND BREAST RECONSTRUCTION SERVICES.....	11
MEDICAL EQUIPMENT AND SUPPLIES .....	11
NEURODEVELOPMENTAL THERAPY .....	12
NEWBORN CARE.....	13
NEWBORN HEARING EXAMS AND TESTING .....	13
NUTRITIONAL THERAPY .....	13
OBSTETRICAL CARE .....	14
PEDIATRIC VISION .....	14
PHENYLKETONURIA (PKU) DIETARY FORMULA.....	14
PREVENTIVE CARE .....	14
PROFESSIONAL VISITS AND SERVICES .....	15
PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING.....	16
REHABILITATION THERAPY AND CHRONIC PAIN CARE .....	16

<b>SKILLED NURSING FACILITIES.....</b>	<b>17</b>
<b>SPINAL AND OTHER MANIPULATIONS.....</b>	<b>17</b>
<b>SURGICAL SERVICES .....</b>	<b>18</b>
<b>TRANSPLANTS .....</b>	<b>18</b>
<b>TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS.....</b>	<b>19</b>
<b>III. WHAT ARE MY PRESCRIPTION DRUG BENEFITS? .....</b>	<b>19</b>
<b>IV. WHAT'S NOT COVERED? .....</b>	<b>20</b>
<b>V. DEFINITIONS.....</b>	<b>26</b>

## **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, and 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 another person of the individual’s age

## **BLOOD PRODUCTS AND SERVICES**

Benefits are provided for the cost of blood and blood derivatives.

## **CLINICAL TRIALS**

Benefits for routine medical care in an approved clinical trial for cancer, including leukemia, lymphoma and bone

marrow stem cell disorders, or for a life-threatening condition other than cancer, are included when the referring health care professional has concluded that the individual's participation in such a trial would be appropriate based upon the individual being eligible to participate in the trial according to the trial protocol.

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 clinical trial are provided as stated above and include the following:

- Prevention, diagnosis, treatment, and palliative care of cancer or a life-threatening condition
- 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 clinical trial

### **Transportation Expenses**

Covered services are limited as follows:

- Transportation provided for the member enrolled in the approved clinical trial
- 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 Clinical Trial's benefit** doesn't cover the following:

- Clinical trials that are not related to cancer or a life-threatening condition
- 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
- 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. Please see the "What Are My Prescription Drug Benefits?" section.
- 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.

### **Pediatric Dental**

Dental care for children up to age 19 is covered consistent with the FEDVIP children's dental plan coverage listed in Appendix B. See Appendix B Pediatric Dental Benefits (under age 19) for coverage details and exclusions.

### **Accidental Injuries**

When services are related to an accidental injury, benefits are provided for the reparation or repair of the natural tooth structure.

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; and
- Not required due to damage from biting or chewing

**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 an annual exam. This benefit also provides coverage for hearing aids – up to one hearing aid per ear every three years. To be covered, benefits must be provided for hearing services or items by an audiologist, otologist, otolaryngologist, physician, or other licensed provider practicing within the scope of their license. 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 and mental health and substance use disorder 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. See the Hospital Inpatient Benefit.

## **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, Sjogren'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. See the Pediatric Vision benefit for available coverage.
- 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.

This benefit is in addition to the Hearing Aids & Exam benefit.

## **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.

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.

## **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.

## **PEDIATRIC VISION**

Vision care for children up to age 19 is covered consistent with the FEDVIP children's vision plan coverage listed in Appendix C. See Appendix C Pediatric Vision Benefits (under age 19) for coverage details and exclusions.

## **PHENYLKETONURIA (PKU) DIETARY 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
- Dental care. See the Dental Coverage benefit for available coverage.
- 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. See the Pediatric Vision benefit for available coverage.

**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
- Mental health and substance use disorder inpatient and outpatient services
- 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
- Dialysis
- Chemotherapy
- Radiation

## **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 state where the provider is practicing and within the scope of services for which the provider is licensed, and in accordance with State of Alaska laws and regulations. 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
- Contraceptive injections or implantable contraceptives. These services are covered under the Contraceptive Management and Sterilization benefit.

## **PSYCHOLOGICAL 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

### **SKILLED 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, including chiropractic care, 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 must not 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".) The insurer reserves 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 the insurer's criteria for coverage. The insurer reviews 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 the insurer's 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. See the Surgical Services benefit for available coverage.

### **Recipient Costs**

This benefit covers transplant and reinfusion-related expenses, including the preparation regimen 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. 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 evaluation and treatment services for TMJ may be covered if they are determined to be medically necessary: diagnostic procedures, non-surgical treatments, and surgical treatments.

This benefit does not include services that are considered:

- Experimental/Investigational Services; or
- Orthodontic Treatment.

## **III. WHAT ARE MY PRESCRIPTION DRUG BENEFITS?**

This benefit provides coverage for medically necessary prescription drugs. The drugs and how many types of drugs that must be covered are designated in CMS publications. Prior authorization or other medical management techniques may be applied, and consumers may seek an appeal if a prescription drug is denied.

Contraceptives must be covered consistent with federal requirements and state law.

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.

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.

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.

#### **Clinical Trials**

- Clinical trials that are not related to cancer or a life-threatening condition other than cancer
- Clinical trials that are not an approved clinical trial as described under 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
- 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
- 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 the insurer's 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
- 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 clinical trial for cancer or a life-threatening condition and as specified in the 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)
- The insurer 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 And Pharmaceutical)**

Benefits are not provided for surgical and pharmaceutical 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) and all obesity drugs and supplements, 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.

### **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 that is not medically necessary, 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. A list of serious adverse events and never events can be obtained from Centers for Medicare and Medicaid Services.

### **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, except as covered by the Pediatric Vision benefit.

### **Vision Hardware**

- Vision hardware (and fittings) used to improve visual sharpness, including eyeglasses and contact lenses and all related supplies, except as covered by the Pediatric Vision benefit.
- 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 if they're exempt from the above laws and if the employer doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the employer. 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.

### **Clinical Trials**

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer or a life-threatening condition, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, consistent with Public Health Service Act Section 2709 and 42 United States Code Section 300gg-8.

### **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 "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.

### **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 individual, 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 – Pediatric Dental Benefits (under age 19)

Covered Services include:

- Class A Basic
  - Diagnostic and Treatment Services
    - D0120 Periodic oral evaluation - Limited to 1 every 6 months
    - D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
    - D0150 Comprehensive oral evaluation - Limited to 1 every 6 months
    - D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months
    - D0210 Intraoral – complete set of radiographic images including bitewings - 1 every 60 (sixty) months
    - D0220 Intraoral - periapical radiographic image
    - D0230 Intraoral - additional periapical image
    - D0240 Intraoral - occlusal radiographic image
    - D0270 Bitewing - single image Adult - 1 set every calendar year/Children - 1 set every 6 months
    - D0272 Bitewings - two images - Adult - 1 set every calendar year/Children - 1 set every 6 months
    - D0274 Bitewings - four images - Adult - 1 set every calendar year/Children - 1 set every 6 months
    - D0277 Vertical bitewings – 7 to 8 images – Adult - 1 set every calendar year/Children - 1 set every 6 months
    - D0330 Panoramic radiographic image – 1 image every 60 (sixty) months
    - D0340 Cephalometric radiographic image
    - D0350 Oral / Facial Photographic Images
    - D0391 Interpretation of Diagnostic Image
    - D0470 Diagnostic Models
  - Preventative Services
    - 
    - D1120 Prophylaxis – Child - Limited to 1 every 6 months
    - D1206 Topical Fluoride - Varnish - Less than age 22 - 2 every 12 months
    - D1208 Topical application of fluoride (excluding prophylaxis) - Less than age 22 - 2 every 12 months
    - D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months
    - D1352 Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.
    - D1510 Space maintainer – fixed – unilateral - Limited to children under age 19
    - D1515 Space maintainer – fixed – bilateral - Limited to children under age 19
    - D1520 Space maintainer - removable – unilateral - Limited to children under age 19
    - D1525 Space maintainer - removable – bilateral - Limited to children under age 19
    - D1550 Re-cementation of space maintainer - Limited to children under age 19
  - Additional Procedures covered as Basic Services
    - D9110 Palliative treatment of dental pain – minor procedure
- Class B Intermediate
  - Minor Restorative Services
    - D2140 Amalgam - one surface, primary or permanent

- D2150 Amalgam - two surfaces, primary or permanent
- D2160 Amalgam - three surfaces, primary or permanent
- D2161 Amalgam - four or more surfaces, primary or permanent
- D2330 Resin-based composite - one surface, anterior
- D2331 Resin-based composite - two surfaces, anterior
- D2332 Resin-based composite - three surfaces, anterior
- D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
- D2910 Re-cement inlay
- D2920 Re-cement crown
- D2929 Prefabricated porcelain crown - primary - Limited to 1 every 60 months
- D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
- D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
- D2940 Protective Restoration
- D2951 Pin retention - per tooth, in addition to restoration
- Endodontic Services
  - D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
  - D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
  - D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
  - D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Periodontal Services
  - D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
  - D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
  - D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy
  - D7921 Collect - Apply Autologous Product - Limited to 1 in 36 months
- Prosthodontic Services
  - D5410 Adjust complete denture – maxillary
  - D5411 Adjust complete denture – mandibular
  - D5421 Adjust partial denture – maxillary
  - D5422 Adjust partial denture - mandibular
  - D5510 Repair broken complete denture base
  - D5520 Replace missing or broken teeth - complete denture (each tooth)
  - D5610 Repair resin denture base
  - D5620 Repair cast framework

- D5630 Repair or replace broken clasp
- D5640 Replace broken teeth - per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture
- D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5740 Reline maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
- D5850 Tissue conditioning (maxillary)
- D5851 Tissue conditioning (mandibular)
- D6930 Recement fixed partial denture
- D6980 Fixed partial denture repair, by report
- Oral Surgery
  - D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
  - D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
  - D7220 Removal of impacted tooth - soft tissue
  - D7230 Removal of impacted tooth – partially bony
  - D7240 Removal of impacted tooth - completely bony
  - D7241 Removal of impacted tooth - completely bony with unusual surgical complications
  - D7250 Surgical removal of residual tooth roots (cutting procedure)
  - D7251 Coronectomy - intentional partial tooth removal
  - D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
  - D7280 Surgical access of an unerupted tooth
  - D7310 Alveoplasty in conjunction with extractions - per quadrant
  - D7311 Alveoplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
  - D7320 Alveoplasty not in conjunction with extractions - per quadrant
  - D7321 Alveoplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
  - D7471 Removal of exostosis

- D7510 Incision and drainage of abscess - intraoral soft tissue
    - D7910 Suture of recent small wounds up to 5 cm
    - D7953 Bone replacement graft for ridge preservation-per site
    - D7971 Excision of pericoronal gingiva
  - Class C Major
    - Major Restorative Services
      - D0160 Detailed and extensive oral evaluation - problem focused, by report
      - D2510 Inlay - metallic – one surface – An alternate benefit will be provided
      - D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided
      - D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided
      - D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
      - D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
      - D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
      - D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
      - D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
      - D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
      - D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
      - D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
      - D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
      - D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
      - D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
      - D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
      - D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months
      - D2794 Crown – titanium– Limited to 1 per tooth every 60 months
      - D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months
      - D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months
      - D2980 Crown repair, by report
      - D2981 Inlay Repair
      - D2982 Onlay Repair
      - D2983 Veneer Repair
      - D2990 Resin infiltration/smooth surface - Limited to 1 in 36 months
    - Endodontic Services
      - D3310 Anterior root canal (excluding final restoration)
      - D3320 Bicuspid root canal (excluding final restoration)
      - D3330 Molar root canal (excluding final restoration)
      - D3346 Retreatment of previous root canal therapy-anterior
      - D3347 Retreatment of previous root canal therapy-bicuspid
      - D3348 Retreatment of previous root canal therapy-molar
      - D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

- D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
- D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
- D3410 Apicoectomy/periradicular surgery - anterior
- D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
- D3425 Apicoectomy/periradicular surgery - molar (first root)
- D3426 Apicoectomy/periradicular surgery (each additional root)
- D3450 Root amputation - per root
- D3920 Hemisection (including any root removal) - not including root canal therapy
- Periodontal Services
  - D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
  - D4211 Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months
  - D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months
  - D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
  - D4241 Gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months
  - D4249 Clinical crown lengthening-hard tissue
  - D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
  - D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
  - D4263 Bone replacement graft - first site in quadrant - Limited to 1 every 36 months
  - D4270 Pedicle soft tissue graft procedure
  - D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
  - D4275 Soft tissue allograft - Limited to 1 every 36 months
  - D4277 Free soft tissue graft 1st tooth
  - D4278 Free soft tissue graft-additional teeth
  - D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime
- Prosthodontic Services
  - D5110 Complete denture - maxillary – Limited to 1 every 60 months
  - D5120 Complete denture - mandibular – Limited to 1 every 60 months
  - D5130 Immediate denture - maxillary – Limited to 1 every 60 months
  - D5140 Immediate denture - mandibular – Limited to 1 every 60 months
  - D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
  - D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

- D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months
- D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
- D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
- **Note:** An **implant** is a covered procedure of the plan only if determined to be a dental necessity..
- D6010 Endosteal Implant - 1 every 60 months
- D6012 Surgical Placement of Interim Implant Body - 1 every 60 months
- D6040 Eposteal Implant – 1 every 60 months
- D6050 Transosteal Implant, Including Hardware – 1 every 60 months
- D6053 Implant supported complete denture
- D6054 Implant supported partial denture
- D6055 Connecting Bar – implant or abutment supported - 1 every 60 months
- D6056 Prefabricated Abutment – 1 every 60 months
- D6057 Custom Abutment - 1 every 60 months
- D6058 Abutment supported porcelain ceramic crown -1 every 60 months
- D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months
- D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months
- D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months
- D6062 Abutment supported cast high noble metal crown - 1 every 60 months
- D6063 Abutment supported cast predominately base metal crown - 1 every 60 months
- D6064 Abutment supported cast noble metal crown - 1 every 60 months
- D6065 Implant supported porcelain/ceramic crown - 1 every 60 months
- D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months
- D6067 Implant supported metal crown - 1 every 60 months
- D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
- D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
- D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
- D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
- D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
- D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
- D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
- D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
- D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months

- D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
  - D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
  - D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months
  - D6080 Implant Maintenance Procedures -1 every 60 months
  - D6090 Repair Implant Prosthesis -1 every 60 months
  - D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months
  - D6095 Repair Implant Abutment - 1 every 60 months
  - D6100 Implant Removal - 1 every 60 months
  - D6101 Debridement periimplant defect, covered if implants are covered - Limited to 1 every 60 months
  - D6102 Debridement and osseous periimplant defect, covered if implants are covered - Limited to 1 every 60 months
  - D6103 Bone graft periimplant defect, covered if implants are covered
  - D6104 Bone graft implant replacement, covered if implants are covered
  - D6190 Implant Index - 1 every 60 months
  - D6210 Pontic - cast high noble metal – Limited to 1 every 60 months
  - D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months
  - D6212 Pontic - cast noble metal– Limited to 1 every 60 months
  - D6214 Pontic – titanium – Limited to 1 every 60 months
  - D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
  - D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
  - D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
  - D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months
  - D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
  - D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months
  - D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
  - D6543 Onlay – metallic – three surfaces - 1 every 60 months
  - D6544 Onlay – metallic – four or more surfaces -1 every 60 months
  - D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
  - D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
  - D6740 Crown - porcelain/ceramic - 1 every 60 months
  - D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
  - D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
  - D6752 Crown - porcelain fused to noble metal - 1 every 60 months
  - D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
  - D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months
  - D6782 Crown - 3/4 cast noble metal - 1 every 60 months
  - D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months
  - D6790 Crown - full cast high noble metal - 1 every 60 months
  - D6791 Crown - full cast predominately base metal - 1 every 60 months
  - D6792 Crown - full cast noble metal - 1 every 60 months
  - D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older
- Class D Orthodontic (under age 19)

- D8010 Limited orthodontic treatment of the primary dentition
- D8020 Limited orthodontic treatment of the transitional dentition
- D8030 Limited orthodontic treatment of the adolescent dentition
- D8050 Interceptive orthodontic treatment of the primary dentition
- D8060 Interceptive orthodontic treatment of the transitional dentition
- D8070 Comprehensive orthodontic treatment of the transitional dentition
- D8080 Comprehensive orthodontic treatment of the adolescent dentition
- D8090 Comprehensive orthodontic treatment of the adult dentition
- D8210 Removable appliance therapy
- D8220 Fixed appliance therapy
- D8660 Pre-orthodontic treatment visit
- D8670 Periodic orthodontic treatment visit (as part of contract)
- D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)).
- General Services
  - Anesthesia Services
    - D9220 Deep sedation/general anesthesia - first 30 minutes
    - D9221 Deep sedation/general anesthesia - each additional 15 minutes
  - Intravenous Sedation
    - D9241 Intravenous conscious sedation/analgesia - first 30 minutes
    - D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes
  - Consultations
    - D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
  - Medications
    - D9610 Therapeutic drug injection, by report
  - Post Surgical Services
- D9930 Treatment of complications (post-surgical) unusual circumstances, by report

Services NOT covered:

- Note: See Temporomandibular Joint (TMJ) Disorder benefit for covered services.
- Class A Basic Exclusions
  - D0320 TMJ arthrogram
  - D0321 Other TMJ images, by report
  - D0322 Tomographic survey
  - D0416 Viral culture
  - D0418 Analysis of saliva example chemical or biological analysis of saliva for diagnostic purposes
  - D0425 Caries test
  - D0431 Adjunctive pre-diagnostic test
  - D0475 Declassification procedure
  - D0476 Special stains for microorganisms
  - D0477 Special stains not for microorganisms
  - D0478 Immunohistochemical stains
  - D0479 Tissue in-situ-hybridization
  - D0481 Electron microscopy
  - D0482 Direct immunofluorescence
  - D0483 In-direct immunofluorescence
  - D0484 Consultation on slides prepared elsewhere
  - D0485 Consultation including preparation of slides
  - D0486 Accession Transepithelial

- D1310 Nutritional counseling
- D1320 Tobacco counseling
- D1330 Oral Hygiene Instruction
- D1555 Removal of fixed space maintainer
- Class B Intermediate Exclusions
  - D7292 Surgical replacement screw retained
  - D7293 Surgical replacement w/surgical flap
  - D7294 Surgical replacement without the surgical flap
  - D7880 TMJ Appliance
  - D7899 TMJ Therapy
  - D7951 Sinus Augmentation – Lateral
  - D7952 Sinus Augmentation of Vertical
  - D7997 Appliance Removal
  - D7998 Intraoral placement of a fixation device
- Class C Major Exclusions
  - D2410 Gold Foil 1 surface
  - D2420 Gold Foil 2 surface
  - D2430 Gold Foil 3 surface
  - D2799 Provisional Crown
  - D2955 Post Removal
  - D2970 Temporary Crown
  - D2975 Coping
  - D3460 Endodontic Implant
  - D3470 Intentional reimplantation
  - D3910 Surgical procedure for isolation of tooth
  - D3950 Canal preparation
  - D4230 Anatomical crown exposure 4 or more teeth
  - D4231 Anatomical crown exposure 1-3 teeth
  - D4320 Splinting intracoronal
  - D4321 Splinting extracoronal
  - D5810 Complete denture upper (interim)
  - D5811 Complete denture lower (interim)
  - D5820 Partial denture upper (interim)
  - D5821 Partial denture lower (interim)
  - D5862 Precision Attachment
  - D5867 Replacement Precision Attachment
  - D5986 Fluoride Gel Carrier
  - D6051 Interim Abutment
  - D6199 Unspecified Implant Procedure, by report
  - D6253 Provisional Pontic
  - D6793 Provisional retainer Crown
  - D6920 Connector bar
  - D6940 Stress breaker
  - D6950 Precision Attachment
  - D6975 Coping
- Class D Orthodontic Exclusions
  - Orthodontic care for members and spouses covered under the standard option.
  - Orthodontic care for dependent children age 19 and over.
  - Repair of damaged orthodontic appliances.
  - Replacement of lost or missing appliance.

- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
- General Services Exclusions
  - D9210 Local Anesthesia not in conjunction with operative or surgical procedures
  - D9211 Regional Block Anesthesia
  - D9212 Trigeminal Division Block Anesthesia
  - D9215 Local Anesthesia
  - D9230 Analgesia, anxiolysis, inhalation of nitrous oxide
  - D9248 Non-intravenous conscious sedation
  - D9410 House/extended care facility call
  - D9420 Hospital Call
  - D9450 Case presentation
  - D9630 Other drugs and or medicaments
  - D9920 Behavior Management
  - D9941 Fabrication of athletic mouthguard
  - D9950 Occlusion analysis - mounted case
  - D9951 Occlusal adjustment - limited
  - D9952 Occlusal adjustment - complete
  - D9970 Enamel microabrasion
  - D9971 Odontoplasty 1-2 teeth
  - D9972 External bleaching - per arch
  - D9973 External bleaching - per tooth
  - D9974 Internal bleaching - per tooth
  - D0310 Sialography
  - D0472 Oral Pathology lab
  - D0473 Oral Pathology lab
  - D0474 Oral Pathology lab
  - D0480 Oral Pathology lab
  - D0502 Oral Pathology lab
  - D5911 Facial Moulage (sectional)
  - D5912 Facial Moulage (complete)
  - D5913 Nasal Prosthesis
  - D5914 Auricular Prosthesis
  - D5915 Orbital Prosthesis
  - D5916 Ocular Prosthesis
  - D5919 Facial Prosthesis
  - D5922 Nasal Septal Prosthesis
  - D5923 Ocular Prosthesis (interim)
  - D5924 Cranial Prosthesis
  - D5925 Facial Augmentation implant
  - D5926 Nasal Prosthesis (replacement)
  - D5927 Auricular Prosthesis (replacement)
  - D5928 Orbital Prosthesis (replacement)
  - D5929 Facial Prosthesis (replacement)
  - D5931 Obturator Prosthesis (surgical)
  - D5932 Obturator Prosthesis (definitive)
  - D5933 Obturator Prosthesis (modification)
  - D5934 Mandibular resection Prosthesis w/guide flange
  - D5935 Mandibular resection Prosthesis w/out guide flange
  - D5936 Obturator Prosthesis (interim)
  - D5937 Trismus Appliance
  - D5951 Feeding Aid
  - D5952 Speech Aid prosthesis (pediatric)
  - D5953 Speech Aid prosthesis (adult)
  - D5954 Palatal Augmentation Prosthesis

- D5955 Palatal Lift Prosthesis (definitive)
- D5958 Palatal Lift Prosthesis (interim)
- D5959 Palatal Lift Prosthesis (modification)
- D5960 Speech Aid Prosthesis (modification)
- D5982 Surgical Stent
- D5983 Radiation Carrier
- D5984 Radiation Shield
- D5985 Radiation Cone locator
- D5987 Commissure Splint
- D5988 Surgical Splint
- D5992 Adjust maxillofacial prosthetic appliance, by report
- D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
- D7285 Biopsy of oral tissue (hard)
- D7286 Biopsy of oral tissue (soft)
- D7295 Harvest of bone for use in autogenous grafting procedures
- D7410 Lesion up to 1.25 (benign)
- D7411 Lesion greater than 1.25 (benign)
- D7412 Complicated lesion (benign)
- D7413 Lesion up to 1.25 (malignant)
- D7414 Lesion greater than 1.25 (malignant)
- D7415 Complicated lesion (malignant)
- D7440 Lesion diameter up to 1.25 (malignant)
- D7441 Lesion diameter greater than 1.25 (malignant)
- D7460 Removal of Benign lesion up to 1.25
- D7461 Removal of Benign lesion greater than 1.25
- D7465 Destruction of lesion (by report)
- D7490 Radical resection upper/lower
- D7530 Removal of foreign body
- D7540 Removal of reaction producing the foreign body
- D7550 Partial Osteotomy
- D7560 Maxillary Sinusotomy
- D7610 Upper open reduction
- D7620 Upper closed reduction
- D7630 Lower open reduction (simple)
- D7640 Lower closed reduction (simple)
- D7650 Open reduction (simple)
- D7660 Closed reduction (simple)
- D7670 Alveolus closed reduction (simple)
- D7671 Alveolus open reduction (simple)
- D7680 Facial bones (simple)
- D7710 Upper open reduction (compound)
- D7720 Upper closed reduction (compound)
- D7730 Lower open reduction (compound)
- D7740 Lower closed reduction (compound)
- D7750 Malar and/or zygomatic arch open red (compound)
- D7760 Malar and/or zygomatic arch closed red (compound)
- D7770 Alveolus open red (compound - stabilization of teeth)
- D7771 Alveolus closed red (compound - stabilization of teeth)
- D7780 Facial bones (compound)
- D7810 TMJ open reduction
- D7820 TMJ closed reduction
- D7830 TMJ manipulation
- D7840 Condylectomy
- D7850 Surgical discectomy
- D7852 Disc repair

- D7854 Synovectomy
- D7856 Myotomy
- D7858 Joint reconstruction
- D7860 Arthrotomy
- D7865 Arthroplasty
- D7870 Arthrocentesis
- D7871 Non-Arthroscopic
- D7872 Arthroscopy with or without a biopsy
- D7873 Arthroscopy surgical adhesions
- D7874 Arthroscopy surgical disc
- D7875 Arthroscopy surgical synovectomy
- D7876 Arthroscopy surgical discectomy
- D7877 Arthroscopy surgical debridement
- D7911 Complicated sutures up to 5 cm.
- D7912 Complicated sutures greater than 5 cm.
- D7920 Skin graft
- D7940 Osteoplasty deformities
- D7941 Osteotomy lower rami
- D7943 Osteotomy lower rami with bone graft
- D7944 Osteotomy segmented
- D7945 Osteotomy body of mandible
- D7946 Lefort I upper total
- D7947 Lefort I upper segmented
- D7948 Lefort II or Lefort III without bone graft
- D7949 Lefort II or Lefort III with bone graft
- D7950 Bone graft - mandible or face
- D7955 Repair of Maxillofacial soft or hard tissue
- D7980 Sialolithotomy
- D7981 Excision of salivary gland
- D7982 Sialodochoplasty
- D7983 Closure of salivary fistula
- D7990 Emergency tracheotomy
- D7991 Coronoidectomy
- D7995 Synthetic graft
- D7996 Implant lower for augmentation purposes
- D9975 External bleaching per arch
- General Exclusions
  - ;
  - Services and treatment which are experimental or investigational;
  - Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
  - Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
  - Services and treatment performed prior to your effective date of coverage;
  - Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
  - Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
  - Services and treatment resulting from your failure to comply with professionally prescribed treatment;

- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD); See Temporomandibular Joint Disorder (TMJ) Benefit for covered services.
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is p
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or o
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for dependent children age 19 and over;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Nitrous oxide;

- Oral sedation;
- Topical medicament center;
- Orthodontic care for a member or spouse covered under the Standard Plan Option;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants.

## Appendix C – Pediatric Vision Benefits (under age 19)

The vision benefits described in this section only apply to Members under age 19.

### Diagnostic Eye Exam

Covered in full every calendar year. Includes dilation, if professionally indicated

### Eyewear

Covered Services also include a choice of prescription glasses or contacts.

#### Lenses

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Lenticular

#### Frames

- High Option: covered once every calendar year
- Standard Option: covered once every other calendar year

Contact Lenses: covered once every calendar year – in lieu of eyeglasses

Covered Services include the following benefits:

- **Medically Necessary Contact Lenses:**

Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear..

- **Low Vision:**

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for covered persons with low vision. Covered low vision services (both in- and out-of-network) will include one comprehensive low vision evaluation every 5 years, with a maximum charge of \$300; maximum low vision aid allowance of \$600 with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of \$100 each visit.

#### General Exclusions

- ;
- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services or materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/ mailing copies of your records or charts;
- State or territorial taxes on vision services and materials;
- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lens designs or coatings other than those described in this document;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;

- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.