

Sec. 21.42.385. Dental, vision, and hearing coverage.

- (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan, including a Medicare supplement policy to the extent not prohibited by 42 U.S.C. 1395 (Social Security Act), shall offer to each plan sponsor or individual minimum dental, vision, and hearing coverage described in (b) of this section. Coverage required under this subsection may be offered as a rider or in a separate policy.
- (b) The minimum coverage required under (a) of this section
 - (1) may be provided under contract with another health care insurer;
 - (2) may not be less than the dental, vision, and hearing coverage provided on July 1, 2009, to an individual entitled to medical benefits under [AS 39.35.535](#) (public employees' retirement system of Alaska); and
 - (3) shall be adjusted by the director on July 1, 2012, and every three years thereafter to correspond to changes in coverage provided to individuals entitled to medical benefits under [AS 39.35.535](#).
- (c) This section does not apply to a health care insurer that has written less than \$300,000 in premiums in the previous calendar year. A health care insurer exempt under this subsection shall disclose the exemption when offering, issuing for delivery, delivering, or renewing a health care insurance plan or an excepted benefits contract, and shall advise the individual covered under the plan that health care insurers that have written more than \$300,000 in premiums in the previous calendar year are required to offer coverage under (a) and (b) of this section.
- (d) This section does not require an insurer who offers only group insurance coverage under AS 21.54 to offer dental, vision, and hearing coverage to an individual.

The following outlines the dental, vision, and hearing coverage provided as of July 1, 2015 to individual's entitled to medical benefits under AS 39.35.535:

Dental Benefit Schedule

Deductible	Standard Plan	Preventive Plan
Annual Individual – (Waived for Class I services)	\$25	\$25
Annual Family Maximum	\$75	\$75

Coinsurance	Standard Plan	Preventive Plan
Class I (preventive) Services	100%	100%
Class II (restorative) services	80%	10%
Class III (prosthetic) services	50%	10%
Orthodontia	50%	Not Covered

Benefit Maximums	Standard Plan	Preventive Plan
Annual Individual Maximum	\$1,500	\$500
Orthodontia Individual Lifetime Maximum	\$1,000	Not Covered

Vision Benefit Schedule

	Network Provider	Out-of-Network Provider
Exams	One per calendar year \$10 copayment 100% after copayment	One calendar year \$10 copayment Maximum reimbursement limit \$100
Lenses*	1 pair per calendar year \$25 copayment 100% after copayment	1 pair per calendar year Maximum reimbursement limit of: Single vision: \$75 Lined bifocal: \$115 Lined trifocal: \$130 Progressive: \$115
Frames	1 pair per two calendar years \$25 copayment 100% after copayment up to \$130 maximum retail allowance (or \$70 allowance at Costco) 20% off amount over allowance	1 pair every two calendar years Maximum reimbursement limit of \$70
Contact lenses (necessary)	\$60 copayment 100% after copayment	Not covered
Contact lenses (elective and in lieu of lenses and frames)	Once per calendar year \$130 allowance for contacts 15% off usual and customary professional fees for evaluation and fitting	Once per calendar year Maximum reimbursement limit of \$105
Low vision supplemental testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	Two tests every two calendar years 100% up to \$125 allowance \$1,000 maximum benefit to all low vision services, testing and materials (including aids below), every two calendar years	Not covered
Low vision supplemental aids	75% coinsurance	Not covered

*Network benefit includes coverage for Antireflective coating, Scratch resistant coating, and Polycarbonate lenses

Audio Benefit Schedule

Coinsurance	
All Services	80%
Benefit Maximum	
Ear Examination Individual Maximum/36 month period	Once per 24 months \$3,000

Dental Plan

4.1. INTRODUCTION

There are two options available under the **dental plan**: preventive and standard. The **coinsurance** amount is different with each option. See *Dental Benefit Schedule*, for details about how these items differ between the options. You elect which option under the **dental plan** you want for you and your **dependents**.

4.2. HOW DENTAL BENEFITS ARE PAID

4.2.1. Deductible

Each **covered person** must meet the annual individual **deductible** before the **dental plan** begins to pay benefits for that **covered person**. The **deductible** is waived for Class I preventive services. See *Dental Benefit Schedule*.

4.2.2. Coinsurance

After you satisfy the annual individual **deductible**, the **dental plan** pays the **coinsurance** amount that applies to you for Class II restorative services and Class III prosthetic services depending on the dental option in which you are enrolled for most **covered expenses**. See *Dental Benefit Schedule*.

4.2.3. Network and Out-of-Network Coverage

You can directly access any network or out-of-network **dentist** or **dental care provider** for covered services and supplies under the **dental plan**. The **dental plan** pays differently when services and supplies are obtained through **network providers** and **out-of-network providers**. **Network providers** have contracted with **Delta Dental** either directly or through a third party to provide services and supplies under the **dental plan**. **Network providers** are identified in **Delta Dental's** printed directory, which can be found online at www.deltadentalak.com.

The **dental plan** provides access to covered benefits through a broad network of health care **providers** and facilities. The **dental plan** is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. **Network providers** have agreed to accept a **negotiated charge** from the **dental plan**. Your **coinsurance** under the **dental plan** will be based on a **negotiated charge** between the **dentist** or **dental care provider** and **Delta Dental**, and you will not have to pay any amount above the **negotiated charge**.

You also have the choice to access licensed **dentists** and **dental care providers** outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use out-of-network **providers** because the **coinsurance** that you are required to pay is usually higher when you utilize out-of-network **providers**. Out-of-network **providers** have not agreed to a **negotiated charge** with **Delta Dental**, and may balance bill you for charges over the **recognized charge** that the **dental plan** pays.

4.2.4. Availability of Providers

Delta Dental cannot guarantee the availability or continued network participation of a particular **dentist** or **dental care provider**. Either **Delta Dental** or any **network provider** may terminate the **provider** contract.

4.2.5. Recognized Charge

The **covered expense** is the part of a charge which is the **recognized charge**. If a charge exceeds the **recognized charge**, the amount above the **recognized charge** is not covered by the **dental plan**, and is your responsibility to pay.

4.2.6. Annual Maximum

The **dental plan** pays **covered expenses** up to an annual individual maximum for each **covered person**. See *Dental Benefit Schedule*.

4.3. COVERED DENTAL SERVICES

The preventive plan covers Class I preventive, Class II restorative, and Class III prosthetic services. The standard plan covers Class I preventive, Class II restorative, and Class III prosthetic services, as well as orthodontic services. This section describes the services covered in each class when performed by a **dentist** or **dental care provider** and when determined to be **dentally necessary**.

4.3.1. Class I Preventive Services

Covered expenses are paid at 100% of the **recognized charge**.

a. Diagnostic Services and Limitations

Services:

- Examination.
- Intra-oral x-rays to assist in determining required dental treatment.

Limitations:

- Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period.
- Complete series x-rays or a panoramic film is covered once in any 5-year period.

- Supplementary bitewing x-rays are covered once in any 12-month period.
- Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
- Only the following x-rays are covered by the dental plan: complete series or panoramic, periapical, occlusal, and bitewing.

b. Preventive Services and Limitations

Services:

- **Prophylaxis** (cleanings).
- Periodontal maintenance.
- Topical application of fluoride.
- Sealants.
- Space maintainers.

Limitations:

- **Prophylaxis** (cleaning) or **periodontal maintenance** is covered once in any 6-month period. Additional cleaning benefit is available for **covered persons** with diabetes, **covered persons** in their third trimester of pregnancy, and covered persons with periodontal disease under the **dental plan's** Oral Health, Total Health program (see section 4.4, *Oral Health, Total Health Program and Benefits*).
- Topical application of fluoride is covered once in any 6-month period for **covered persons** age 18 and under. For **covered persons** age 19 and over, topical application of fluoride is covered once in any 6-month period if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
- Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth, during any 5-year period.
- Space maintainers are limited to once per space. Space maintainers for primary **anterior** teeth, missing permanent teeth or for **covered persons** age 14 or over are not covered.

4.3.2. Class II Restorative Services

Covered expenses are paid at 80% of the **recognized charge** for the standard plan and 10% of the **recognized charge** for the preventive plan.

a. Restorative Services and Limitations

Services: Fillings on teeth for the treatment of decay.

Limitations:

- Inlays are considered an optional service; an alternate benefit of a composite filling will be provided.
- Crown buildups are considered to be included in the crown **restoration** cost. A buildup will be a benefit only if necessary for tooth retention.
- Additional limitations when teeth are restored with crowns or **cast restorations** are in section 4.3.3, *Class III Prosthetic Services*.
- A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

b. Oral Surgery Services and Limitations

Services:

- Extractions (including surgical).
- Other minor surgical procedures.

Limitations:

- A separate, additional charge for **alveoloplasty** done in conjunction with surgical removal of teeth is not covered.
- Surgery on larger lesions or malignant lesions is not considered minor surgery.
- Brush biopsy is covered once in any 6-month period. Benefits for are limited to the sample collection and do not include coverage for pathology (lab) services.

c. Endodontic Services and Limitations

Services: Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

Limitations:

- A separate charge for cultures is not covered.
- Pulp capping is covered only when there is exposure of the

pulp.

- Cost of retreatment of the same tooth by the same **dentist** within 24 months of a root canal is not eligible for additional coverage.

d. Periodontic Services and Limitations

Services: Treatment of diseases of the gums and supporting structures of the teeth and/or **implants**.

Limitations:

- Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
- Coverage for **periodontal maintenance** procedure under Class I, Preventive.
- A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
- Full mouth **debridement** is limited to once in a 3-year period and only if there has been no cleaning (**prophylaxis, periodontal maintenance**) within 24 months.

e. Anesthesia Services

- General anesthesia or IV sedation in conjunction with a covered surgical procedures performed in a dental office).
- General anesthesia or IV sedation when necessary due to concurrent medical conditions.

4.3.3. Class III Prosthetic Services

Covered expenses are paid at 50% of the **recognized charge** for the standard plan and 10% of the **recognized charge** for the preventive plan.

a. Restorative Services and Limitations

Services: **Cast restorations**, such as crowns, onlays or lab **veneers**, necessary to restore decayed or **broken** teeth to a state of functional acceptability.

Limitations:

- **Cast restorations** (including **pontics**) are covered once in a seven year period on any tooth.
- Porcelain **restorations** are considered **cosmetic** dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the **covered person** is responsible for paying the difference.

b. Prosthodontic Services and Limitations

Services:

- **Bridges.**
- Partial and complete dentures.
- Denture **relines.**
- Repair of an existing prosthetic device.
- **Implants.**

Limitations:

- A **bridge** or denture (full or partial denture) will be covered once in a seven year period and only if the tooth, tooth site, or teeth involved have not received a **cast restoration** benefit in the last seven years.
- Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
- Partial dentures: A temporary (interim) partial denture is only a benefit when placed within two months of the extraction of an **anterior** tooth or for missing **anterior** permanent teeth of **covered persons** age 16 or under. If a specialized or precision device is used, **covered expense** will be limited to the cost of a standard cast partial denture. No payment is provided for **cast restorations** for partial denture **retainer** teeth unless the tooth requires a **cast restoration** due to decayed or **broken** teeth.
- Denture adjustments, repairs, and **relines**: A separate, additional charge for denture adjustments, repairs, and **relines** done within six months after the initial placement is not covered. Subsequent **relines** will be covered once per denture in a 12-month period. Subsequent adjustments are limited to two adjustments per denture in a 12-month period.
- Tissue conditioning is covered no more than twice per denture in a 36-month period.
- Surgical placement and removal of **implants** are covered. **Implant** placement and **implant** removal are limited to once per lifetime per tooth space. The dental plan will also cover:
 - The final crown and **implant abutment** over a single **implant**. This benefit is limited to once per tooth or tooth space over the lifetime of the **implant**; or

- Provide an alternate benefit per arch of a full or partial denture for the final **implant supported prosthetic** when the **implant** is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any seven year period); or
- The final **implant supported prosthetic bridge retainer** and **implant abutment**, or **pontic**. The benefit is limited to once per tooth or tooth space in any seven year period.
- **Implant supported prosthetic bridges** are not covered if one or more of the **retainers** is supported by a natural tooth.
- These benefits or alternate benefits are not provided if the tooth, **implant**, or tooth space received a **cast restoration** or prosthodontic benefit, including a **pontic**, within the previous seven years.
- Fixed **bridges** or removable cast partial dentures are not covered for **covered persons** under age 16.
- Porcelain **restorations** are considered **cosmetic** if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The **covered person** is responsible for paying the difference.

c. Other Services and Limitations

Services: Athletic mouthguard.

Limitations:

- An athletic mouthguard is covered once in any 12 month period for **covered persons** age 15 and under and once in any 24-month period age 16 and over.

4.3.4. General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, the **dental plan** will pay the applicable percentage of the **recognized charge** for the least costly treatment. The **covered person** will be responsible for the remainder of the **dentist's** fee.

4.4. ORAL HEALTH, TOTAL HEALTH PROGRAM AND BENEFITS

The **dental plan** covers additional cleanings (**prophylaxis** or **periodontal maintenance**) for certain **covered persons**. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in section 4.3, *Covered Dental Services*.

The following **covered persons** should consider enrolling in this program:

- **Diabetics**

For **covered persons** with diabetes, elevated blood sugar levels can have a negative effect on oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the **dentist** may help in the diagnosis and management of diabetes. Diabetic **covered persons** are eligible for a total of four cleanings per calendar year.

- **Pregnant Persons**

Keeping the mouth healthy during a pregnancy is important for a **covered person** and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Covered persons should talk to their **dentist** about scheduling a routine cleaning or **periodontal maintenance** during the third trimester of pregnancy. Pregnant **covered persons** are eligible for a cleaning in the third trimester of pregnancy regardless of normal plan frequency limits.

4.5. ORTHODONTIC BENEFITS AND LIMITS

Orthodontic services are defined as the procedures of treatment for correcting malocclusioned teeth.

The standard plan will pay 50% of the **recognized charge** for orthodontic services, up to the orthodontic lifetime maximum. See section 2.2, *Dental Benefit Schedule*. This lifetime maximum is not included in the **dental plan's** annual individual maximum. The **deductible** does not apply to orthodontic services.

The **dental plan's** obligation to make payments for treatment will end when treatment stops for any reason prior to completion, or upon termination of eligibility or of the **dental plan**.

If treatment began before the **covered person** was eligible under the **dental plan**, payment will be based on the balance of the dentist's normal payment pattern. The orthodontic lifetime maximum will apply to this amount.

Repair or replacement of an appliance furnished under the **dental plan** is not covered.

4.6. DENTAL PLAN EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the **dental plan**, the following services, procedures and conditions are not covered, even if otherwise **dentally necessary**, if they relate to a condition that is otherwise covered by the **dental plan**, or if recommended, referred, or provided by a **dentist** or **dental care provider**.

1. Services covered under the **medical plan**.
2. General anesthesia and/or IV sedation, except as stated in section 4.3, *Covered Dental Services*.
3. Anesthetics, analgesics, hypnosis, and medications, including nitrous oxide, local anesthetics or any other prescribed drugs.
4. Services or supplies not specifically described in the dental plan as covered dental services.
5. Claims submitted more than 12 months after the date of service.
6. Congenital or developmental malformations, including, but not limited to treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth).
7. **Cosmetic** services.
8. **Experimental or investigational** procedures, including expenses incidental to or incurred as a direct consequence of such procedures.
9. Facility fees, including additional fees charged by the dentist for hospital, extended care facility or home care treatment.
10. Gnathologic recordings.
11. Illegal acts, riot or rebellion, including services and supplies for treatment of an injury or condition caused by or arising out of active covered person's voluntary participation in a riot, armed invasion or aggression or rebellion or arising directly from an illegal act.
12. Instructions or training, including plaque control and oral hygiene or dietary instruction.
13. Localized delivery of antimicrobial agents.
14. Missed appointment charges.
15. Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.
16. Periodontal charting.
17. Precision attachments.
18. Rebuilding or maintaining chewing surface and stabilizing teeth, including services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).
19. Services on tongue, lip or cheek.

20. Services otherwise available, including:
- Those compensable under workers' compensation or employer's liability laws.
 - Those provided by any city, county, state or Federal law, except for Medicaid coverage.
 - Those provided, without cost to the **covered person**, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the **dental plan**.
 - Any condition, disease, ailment, **injury** or diagnostic service to the extent that benefits are provided or would have been provided had the **covered person** enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended.
 - Those provided under separate contracts that are used to provide coordinated coverage for **covered persons** and are considered parts of the same plan.
21. Services provided by a relative, which includes a **covered person**, a **spouse**, **same-sex partner**, child, sibling, or parent of a **covered person** or his or her **spouse** or **same-sex partner**.
22. Services and supplies for treatment of **illness** or **injury** for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a **covered person**, whether or not such benefits are requested. See section 11, *Subrogation and Reimbursement Rights*.
23. Treatment of any disturbance of the temporomandibular joint (TMJ).
24. Treatment after coverage terminates, except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a **covered person's** eligibility ends. This provision is not applicable if the **Division** transfers the **dental plan** to another **claims administrator**.
25. Treatment before coverage begins under the **dental plan**.
26. Treatment that is not **dentally necessary**, including services not established as necessary for the treatment or prevention of a dental **injury** or disease otherwise covered under the **dental plan**; that are inappropriate with regard to standards of good dental practice; with poor prognosis.

4.7. ADVANCE CLAIM REVIEW FOR DENTAL CLAIMS

Before beginning expensive treatment, ask your **dentist** to file a description of the proposed course of treatment and expected charges with **Delta Dental**. **Delta Dental** will review the proposal and advise you and your **dentist** of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more **providers** for the treatment of a condition diagnosed by the attending **physician** or **dentist** as a result of an examination. It begins on the day the **provider** first renders the service to correct or treat such a condition. **Emergency** treatments, oral examinations, **prophylaxis**, and dental x-rays are considered part of a course of treatment.

By receiving an advance review, you will eliminate the possibility of unexpected claim denials.

As part of advance claim review and for any claim, **Delta Dental**, at its expense, has the right to require you to obtain an oral examination. You must furnish to **Delta Dental** all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports.

Vision Plan

5.1. INTRODUCTION

The **vision plan** will pay for covered expenses up to the limits and maximums shown in the *Vision Benefit Schedule*.

5.2. HOW VISION BENEFITS ARE PAID

5.2.1. Deductible

You pay no **deductible** under the **vision plan**.

5.2.2. Copayment

Each **covered person** must pay any applicable **copayment** before the **vision plan** will pay any benefits for that covered service. See *Vision Benefit Schedule*.

5.2.3. Coinsurance

The **vision plan** pays 100% of the **recognized charges** for covered vision and optical services, less any applicable **copayment**.

5.2.4. Annual Allowances

The **vision plan** pays **covered expenses** up to an annual allowance for certain services. See *Vision Benefit Schedule*.

5.2.5. Network Providers

If you choose a **VSP doctor** or an **affiliated provider** under the **vision plan**, you will lower your out-of-pocket costs. See *Vision Benefit Schedule*. **VSP doctors** are located in retail, neighborhood, medical and professional settings, and include Costco Optical, Visionworks, Cohen's Fashion Optical,

Wisconsin Vision, and RX Optical. You have the freedom to choose any **provider**, national retailer, or local retail chain.

For a list of **VSP doctors**, call **VSP** at the number listed in the front of this **plan** or visit www.vsp.com/. Select a **VSP doctor** from the list and make an appointment. You must identify yourself as a **covered person** under the **vision plan** when you make the appointment. The **VSP doctor** will contact **VSP** to determine what benefits you are eligible for. If you do not identify yourself as a **covered person**, and the **VSP doctor** does not contact **VSP**, your benefits will be paid out-of-network.

5.3. COVERED VISION SERVICES

The following services and supplies are covered under the **vision plan**.

5.3.1. Vision Exam

Covered expenses include a complete initial vision analysis including an appropriate examination of visual functions and the **prescription** of corrective eyewear where indicated by a legally qualified ophthalmologist. Subsequent regular eye examinations are covered once every calendar year.

5.3.2. Vision Supplies

Covered expenses include charges for lenses and frames, or prescription contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.

- **Prescription Lenses**

Covered expenses include one pair of **prescription** single vision, lined bifocal, lined trifocal, or lenticular lenses per calendar year. The following lens options are covered in full with a **VSP doctor** at no additional cost to the **covered person**:

- Progressive lenses
- Anti-reflective coating
- Scratch resistant coating
- Polycarbonate lenses

- **Frames**

Covered expenses include a frame every two calendar years up to the allowance set forth in the *Vision Benefit Schedule*. There is a 20% discount for any out-of-pocket cost over the frame allowance. The frame allowance may be applied towards non-**prescription** sunglasses for post PRK, Lasik, or Custom LASIK patients.

Some brands of spectacle frames may be unavailable for purchase under the **vision plan**, or may be subject to additional limitations. **Covered persons** may obtain details regarding frame brand

availability from their **VSP doctor** or by calling **VSP** at the number in the front of the **plan**.

- **Additional Services**

The following professional services are included in lens and frame coverage:

- Prescribing and ordering proper lenses
- Assisting in the selection of frames
- Verifying the accuracy of the finished lenses
- Proper fitting and adjustment of frames
- Subsequent adjustments to frames to maintain comfort and efficiency
- Progress or follow-up work as necessary

- **Contact Lenses**

Elective contact lenses are available once every calendar year in lieu of all other lens and frame benefits under the **vision plan**. Prior approval by **VSP** is not required for **covered persons** to be eligible for necessary contact lenses.

- **Low Vision Benefit**

The low vision benefit is available to **covered persons** who have severe visual problems that are not correctable with regular lenses. The **vision plan** covers complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, and the **prescription** of corrective eyewear or vision aids where indicated. Supplemental care aids are also covered. The low vision benefit is subject to the maximums set forth in *Vision Benefit Schedule*.

5.4. VISION PLAN EXCLUSIONS

The **vision plan** is designed to cover visual needs rather than **cosmetic** materials. When the **covered person** selects any of the following extras, the **vision plan** will pay the basic cost of the allowed lenses or frames, and the **covered person** will pay the additional costs for the options:

- Optional **cosmetic** processes
- Color coating
- Mirror coating
- Blended lenses
- Cosmetic lenses

- Laminated lenses
- Oversized lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the **vision plan** allowance
- Contact lenses, except as provided in section 5.3, *Covered Vision Services*.

The following services, procedures and conditions are not covered under the **vision plan**, even if they relate to a condition that is otherwise covered by the **vision plan** or if recommended, referred or provided by a **VSP doctor**.

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a $\pm .50$ diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under the **vision plan** which are lost or broken, except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Corrective vision treatment that is **experimental or investigational**.
5. Costs for services and/or materials above the **vision plan** allowance.
6. Services and/or materials not listed as covered services in section 5.3, *Covered Vision Services*.

VSP may, at its discretion, waive any of these limitations if, in the opinion of **VSP's** optometric consultants, it is necessary for the visual welfare of the **covered person**.

Audio Services

Covered expenses include the following audio services:

- An otological (ear) examination by a **physician** or surgeon every 24 consecutive months.
- An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow up consultation.
- An electronic hearing aid (monaural or binaural) prescribed as a result of the examination. This includes ear mold(s), hearing aid instrument, initial batteries, cords, and other necessary supplementary equipment as well as warranty and follow-up consultation within 30 days following delivery of the hearing aid. Hearing aids are limited to one in a rolling 36 month period, and are subject to the maximums set forth in the *Medical Benefit Schedule*.
- Repairs, servicing or alteration of hearing aid equipment.

You must provide **Aetna** with written certification from the examining **physician** explaining that you are suffering a hearing loss that may be lessened by the use of a hearing aid.

Expenses incurred for a hearing aid within 30 days of termination of the **covered person's** coverage under the **medical plan** will be **covered expenses** under the **medical plan** if during the 30 days before the date coverage terminates:

- the **prescription** for the hearing aid was written; and
- the hearing aid was ordered.

Exclusion

Charges made for the following are not covered except to the extent listed under *Covered Medical Expenses*.

Hearing services that do not meet professional standards; hearing exams given during a **stay** in a **hospital** or other facility; replacement parts or repairs for a hearing aid; and any tests, appliances and devices for the improvement of hearing (including hearing aids and amplifiers); or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech