Benefits for Health Care Coverage

Virginia Benchmark Plan

Commonwealth of Virginia

STATE CORPORATION COMMISSION

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I. At a Glance – Covered and Not Covered

Disclaimer

This Virginia Essential Health Benefits (EHB) Benchmark Plan provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart 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 2025 Benchmark Plan should be construed as additional Essential Health Benefits (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.

Table 1. List of Benefits

Category	Covered	Minimum Requirements	Page Number and Service Notes
Abortions for which Public Funding is Prohibited			
Accidental Dental	√		Pg. 10
Acupuncture			
Allergy Testing	√		Pg. 7
Bariatric Surgery			
Basic Dental Care - Adult			
Basic Dental Care- Child	√		Pg. 36
Chemotherapy	√		Pg. 30
Chiropractic Care	√		Pg. 30
Cosmetic Surgery			
Clinical Trials and Studies	√		Pgs. 9-10
Delivery and All Inpatient Services for Maternity Care	√		Pg. 19
Dental Check-Up for Children	√		Pg. 36
Dental Anesthesia	√		Pg. 10
Diabetes Education	√		Pg. 10
Diabetes Care Management	√		Pg. 10
Dialysis	√		Pg. 30
Durable Medical Equipment	√		Pgs. 12-13
Early Intervention Services	√		Pg. 14
Emergency Room Services	√		Pgs. 14-15
Emergency Transportation/Ambulance	√		Pgs. 7-8
Eyeglasses for Children	√		Pgs. 31, 32
Family Planning Services			Pgs. 19-20

Category	Covered	Minimum Requirements	Page Number and Service Notes
Habilitation Services	√		Pgs. 26, 29
Hearing Aids			
Home Health Care Services	√	100 visits per Benefit Period	Pg. 15-16
Hospice Care	√		Pg. 16
Imaging (CT/PET Scans, MRIs)	√		Pg. 11-12
Infertility Treatment			Pg. 21
Infusion Therapy	√		Pg. 30
Inherited Metabolic Disorder	√		Pgs. 13, 33, 34, 35, 50, 51
Inpatient Hospital Services (e.g., Hospital Stay)	√		Pg. 18
Inpatient Physician and Surgical Services	√		Pg. 18
Laboratory Outpatient and Professional Services	√		Pg. 11
Long-Term/Custodial Nursing Home Care			
Major Dental Care - Adult			
Major Dental Care - Child	√		Pg. 37
Mental Health/Behavioral Health Inpatient Services	√		Pg. 21
Mental Health/Behavioral Health Outpatient Services	√		Pg. 21
Nutritional Counseling	√		Pg. 22
Orthodontia - Adult			
Orthodontia - Child	√		Pg. 38
Other Practitioner Office Visit (Nurse, Physician Assistant)	√		Pg. 22
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	√		Pg. 23
Outpatient Rehabilitation Services	√		Pg. 26
Outpatient Surgery Physician/Surgical Services	√		Pgs. 27-28
Prenatal and Postnatal Care	√		Pg. 19
Preventive Care/Screening/Immunizations	√		Pgs. 23, 24, 25
Primary Care Visit to Treat an Injury or Illness	√		Pg. 22
Private Duty Nursing	√	16 hours per Benefit Period	Pg. 25
Prosthetic Devices	√		Pg. 13
Radiation	√		Pg. 30
Reconstructive Surgery	√		Pg. 28
Rehabilitative Occupational and Rehabilitative Physical Therapy	√	30 visits per Benefit Period, combined	Pgs. 26, 29

Category	Covered	Minimum Requirements	Page Number and Service Notes
Rehabilitative Speech Therapy	√	30 visits per Benefit Period	Pgs. 26, 29
Routine Dental Services (Adult)			
Routine Eye Exam (Adult)			
Routine Eye Exam (Children)	√		Pg. 31
Routine Foot Care			
Skilled Nursing Facility	√	100 days per stay	Pg. 27
Specialist Visit	√		Pg. 22
Substance Use Disorder Inpatient Services	√		Pg. 21
Substance Use Disorder Outpatient Services	√		Pg. 21
Telehealth Services	√		Pg. 29
Transplant	√		Pgs. 17-18
Treatment for Temporomandibular Joint Disorders	√		Pgs. 29
Urgent Care Centers or Facilities	√		Pgs. 22, 31
Weight Loss Programs			Pgs. 44
Well Baby Visits and Care	√		Pgs. 19, 24
X-rays and Diagnostic Imaging	√		Pg. 11
Generic Drugs	√		Pgs. 33, 34
Non-Preferred Brand Drugs	√		Pgs. 33, 34
Preferred Brand Drugs	√		Pgs. 33, 34
Specialty Drugs	√		Pgs. 33, 34

II. Detail of Benefits

Disclaimer
To the extent that the Benchmark Plan does not comply with federal requirements, including 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 federal law.

Covered Services are provided without discrimination based on or consistent with a person's Gender Identity or status as a Transgender Individual, including coverage of Medically Necessary Transition-Related Care. Medical Necessity will be assessed according to nondiscriminatory criteria that are consistent with current medical standards.

Allergy Services

Covered Services include Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance.

For ground ambulance, you are taken:
- From your home, the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when we require you to move from an out-of-network Hospital to an in-network Hospital; or
- Between a Hospital and a Skilled Nursing Facility or other approved Facility.

For air or water ambulance, you are taken:
- From the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when we require you to move from an out-of-network Hospital to an in-network Hospital; or
- Between a Hospital and an approved Facility.

Prior authorization is not required for ambulance services for Emergency Medical Conditions. Ambulance services are subject to Medical Necessity reviews.

You must be taken to the nearest Facility that can give care for your condition, unless otherwise approved.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Exclusion: Air ambulance will not be covered if you are taken to a Facility that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats you cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

Behavioral Health Services

Please see "Mental Health and Substance Use Disorder Services".

Blood and Administration of Blood Products

Covered Services include blood and the administration of blood products for the treatment of hemophilia and congenital bleeding disorders.

Cardiac Rehabilitation

Please see "Therapy Services".

Chemotherapy

Please see "Therapy Services".

Chiropractor Services

Please see "Therapy Services".

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health.

    b. The Centers for Disease Control and Prevention.

    c. The Agency for Health Care Research and Quality.

    d. The Centers for Medicare & Medicaid Services.

    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

You may be required to use an in-network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational. All other requests for clinical trials services that are not part of approved clinical trials may be reviewed for approval.

Any of the following services may be excluded:

i. The Investigational item, device, or service, itself;

ii. Items and services given only to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient;

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or

iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Covered Services include dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth, or face due to an accident. An injury that results from chewing or biting is not considered an Accidental Injury under the plan. Dental appliances required to diagnose or treat an Accidental Injury to the teeth, and the repair of dental appliances damaged as a result of Accidental Injury to the jaw, mouth, or face, are also covered.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under the plan.

Hospitalization for Anesthesia and Dental Procedures

Covered Services include general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery Facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to provide dental care effectively and safely.

Diabetes Equipment, Education, and Supplies

Covered Services include medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles;
- outpatient self-management training and education; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional; and
- Routine foot care for treatment of corns, calluses, and care of toenails when provided by appropriately licensed or registered health care professionals.

Diabetic education may be received from Pharmacies that are authorized to perform this service. Contact the Pharmacy to determine if they are authorized to perform this service.

Screenings for gestational diabetes are covered under "Preventive Care."

Diagnostic Services

Covered Services include tests or procedures to find or check a condition when specific symptoms exist, as well as benefits for interpretation of diagnostic tests such as imaging, pathology, and cardiology reports. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Sleep Testing

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Radiology (including mammograms), ultrasound or nuclear medicine
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans

- QCT Bone Densitometry
- Diagnostic CT Colonography
- Single photon emission computed tomography (SPECT) scans

The list of advanced imaging services may change as medical technologies change.

Dialysis

Please see "Therapy Services".

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies, Medically Necessary Formula and Enteral Nutrition Products, and Devices and Supplies for Sleep Treatment

Durable Medical Equipment and Medical Devices

Covered Services include benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable;
- Is used for a medical purpose and is of no further use when medical need ends;
- Is meant for use outside a medical Facility;
- Is only for the use of the patient;
- Is made to serve a medical use; and
- Is ordered by a Provider.

Benefits include rental (or purchase if less expensive) of multi-use and non-disposable equipment that has no other use than medical and is ordered by a health care provider for use outside a medical facility. Also, maintenance and supplies needed for use of the equipment, such as a battery for a powered wheelchair are covered as well as necessary repairs except if damage is due to neglect. Covered equipment includes oxygen concentrator, ventilator, oxygen and equipment for administration, cochlear implants, negative pressure wound therapy devices, nebulizers, hospital-type beds, wheelchairs, traction equipment, walkers, and crutches.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Orthotics

Benefits include coverage for certain types of orthotics (braces, boots, splints), other than foot orthotics (unless Medically Necessary). Covered Services include the initial purchase, fitting, adjustment, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Covered Services include benefits for prosthetic devices and components when determined by peer-reviewed medical literature to be medically appropriate based on the clinical assessment of your rehabilitation potential. A prosthetic device includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, hand, leg, foot or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.

Covered Services may include, but are not limited to:

1) Artificial limbs and components (the materials and equipment needed to ensure the comfort and functioning of the prosthetic device).

2) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.

3) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.

4) Restoration prosthesis (composite facial prosthesis)

5) Wigs needed after cancer treatment.

Minimum Requirement: One wig per Benefit Period.

Medical and Surgical Supplies

Covered Services include medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, hypodermic needles, surgical dressings, splints, and other similar items that serve only a medical purpose.

Exclusion: Items often stocked in the home for general use like adhesive bandages, thermometers, and petroleum jelly.

Medical Formula and Enteral Nutrition Products

Covered Services include Medically Necessary Formula and Enteral Nutrition Products prescribed or ordered by a qualified health care professional to manage an Inherited Metabolic Disorder by means of oral intake or enteral feeding by tube, as managed by a medical professional in a setting that includes a home setting. Coverage will include medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products.

Medically Necessary Formula and Enteral Nutrition Products shall be classified as medicine and covered on the same terms and conditions imposed on other medicines covered under the plan.

Coverage will include the partial or exclusive feeding by means of oral intake or enteral feeding by tube and any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products.

Devices and Supplies for Sleep Treatment

Covered Services include devices and supplies, such as APAP, CPAP, BPAP and oral devices for sleep treatment. These services are subject to Medical Necessity reviews.

Early Intervention Services

Covered Services include early intervention services for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part H of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the Exclusion of services that are not Medically Necessary. The benefit maximums for physical, occupational, and speech therapy will not apply if you get that care as part of the Early Intervention benefit.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital emergency room or freestanding emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency,"" or "Emergency Medical Condition" means regardless of the covered person's final diagnosis, a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's mental or physical health in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems,

unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

"Emergency Care" means a medical screening exam within the capabilities of the emergency department of a Hospital or a freestanding emergency Facility and includes services routinely available in the emergency department to evaluate an emergency condition. Services include diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans to evaluate and treat a patient with an Emergency Medical Condition. It includes any further medical exams and treatment required to stabilize the patient. Emergency care for mental health conditions or substance use disorders may be provided by a facility and staff credentialed to provide behavioral health crisis services.

If you are experiencing an Emergency call 911 or visit the nearest Hospital or freestanding Emergency Facility for treatment.

Medically Necessary services will be covered whether you get care from an In-network or Out-of-network Provider. Emergency Care you get from an Out-of-network Provider will be covered as an In-network service. Coverage shall be provided without need for any prior authorization

Your Doctor should call the carrier as soon as possible if you are admitted to the Hospital from the emergency room. The carrier decides if a Hospital stay is needed and for how long. The plan does not pay for services determined not to be Medically Necessary.

Treatment you get after your condition has stabilized and You are able to travel to an In-network Provider or Facility located within a reasonable travel distance using non-medical or nonemergency medical transport is not Emergency Care.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home or through remote patient monitoring. Benefits include visits by licensed health care professionals including nurses, therapists, or home health aides. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other

organizations may give services only when approved, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.

- Physical, Speech, and Occupational Therapy Services (Manipulation Therapy will not be covered when given in the home) Separate visit limits do not apply to physical, speech, and occupational therapy services when provided as part of home care. Visit limits do not apply when Home Care Services are received for a mental health condition or substance use disorder
- Medical supplies
- Durable medical equipment

Home Infusion Therapy

Please see "Therapy Services".

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term Inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute Inpatient care for the covered person in order to provide the covered person's primary caregiver a temporary break from caregiving responsibilities.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, (therapy visit limit does not apply to physical, occupational, and speech therapy received under this benefit.)
- Respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers, and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than six months to live.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of the plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Covered Services include Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular Inpatient and outpatient benefits of the plan.

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

- Medically Necessary human organ, tissue, and stem cell/bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest, and storage.
- Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.
- Coverage includes complications from the donor procedure for up to 6 weeks from the date of procurement.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered under the same policy, each will get benefits. If only the recipient is covered, services for the donor, including complication from the donor procedure for up to 6 weeks from the date of procurement, will be covered only to the extent benefits are not available from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

Exclusion: Services and supplies are excluded if the donor is covered but not the recipient.

Transportation and Lodging

Covered Services include the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the covered transplant procedure will be performed. Travel costs includes transportation to and from the Facility and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered services for transportation and lodging include, but are not limited to:

- Childcare,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, unless specifically approved under the plan,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,

- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation, and
- Meals.

Infertility Services

Please see "Maternity and Reproductive Health Services".

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit may be approved. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Blood and blood products.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.

- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the Doctor who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Lymphedema

Covered Services include benefits for expenses incurred in connection with the treatment of lymphedema, including benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a pregnancy and for services needed for a miscarriage. Covers maternity care, and maternity-related checkups. Prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary. Refer to the “Preventive Care” section for additional covered benefits.

Covered maternity services are for a Subscriber or a covered dependent and include:

- Pregnancy testing.
- Professional and facility services for childbirth including use of the delivery room and care for deliveries, in a Facility or the home, including the services of an appropriately licensed nurse midwife, coverage includes delivery and all Inpatient services for maternity care.
- Anesthesia services to provide partial or complete loss of sensation before delivery.
- Routine nursery care for the newborn during the mother’s normal Hospital stay, including circumcision of a covered male Dependent.
- Prenatal and postpartum services for the mother, including Inpatient and home visits.
- Postnatal services for the baby, including behavioral assessments and measurements, screening for blood pressure, hearing screening, hemoglobinopathies screening; gonorrhea prophylactic medication; hypothyroidism screening, PKU screening.
- Dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Fetal screenings, which are genetic or chromosomal tests of the fetus. Also, anatomical, biochemical, or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies.

The following preventive services are also covered:

- Screening for pregnant women, gestational diabetes, hepatitis B, Rh incompatibility, and urinary tract or other infection.

- Coverage for folic acid supplement.
- Coverage for expanded tobacco intervention and counseling for pregnant users.
- Breast feeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Diabetes screening after gestational diabetes.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an in-network Provider to have Covered Services covered at the In-network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-network level even if an Out-of- Network Provider. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the normal post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Inter-hospital Transfer of Mother with Infant

Preauthorization is not required for the interhospital transfer of a newborn infant experiencing a life-threatening Emergency Medical Condition or the hospitalized mother of such newborn infant to accompany the infant.

Contraceptive Benefits

Benefits include oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.

Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Sterilizations for women are covered under the "Preventive Care" benefit.

Exclusion: Reversals of elective sterilizations

Abortions for Which Public Funding is Prohibited

Voluntary, elective abortions and any related services, drugs or supplies are excluded from the plan, but may be covered by the carrier.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life of the mother (when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life endangering physical condition arising from the pregnancy itself) or, when the pregnancy is the result of an alleged act of incest or rape.

Infertility Services

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** including Inpatient professional charges in a Hospital or any Facility that we must cover per state law. Inpatient benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, convulsive therapy, detoxification, and rehabilitation.

- **Outpatient Services** including physician charges and diagnosis and treatment of psychiatric conditions in an outpatient Facility and office visits. Covered services include individual psychotherapy, group psychotherapy, psychological testing and medication management visits (visits to your physician to make sure that the mediation you are taking for a mental health or substance use disorder is working and the dosage is right for you).

- **Partial Day Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital. A partial day program must be licensed or approved by the state and must include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance use disorder, or an intensive outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.

- **Residential Treatment** which includes coverage for Inpatient services for substance use disorders, and other mental health conditions provided in a hospital or treatment facility that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour a day nursing care. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a mental health or substance use disorder provider,
    - Rehabilitation, therapy, education, and recreational or social activities.

- **Treatment for Autism** is covered under the plan. Virginia law defines autism as a mental health condition. Virginia law requires coverage of mental health conditions. As such,

Medically Necessary behavioral health treatment for autism including Applied Behavioral Analysis is covered under the plan.

Medically necessary as used here, means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) 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 capacities that are appropriate for individuals of the same age.

Occupational Therapy

Please see "Therapy Services."

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury, including surgery.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care Services" benefit described earlier.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major Pharmacies or retail stores. Health care services are typically given by physician's assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Specialist Office Visit including office surgeries and second opinion.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent care includes treatment at an Urgent Care Center for urgent but non-emergent care as described in "Urgent Care Services.".

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat, or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Nutritional Counseling

Prescription Drugs Administered in the Office, including allergy serum.

Orthotics

Please see "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies.".

Outpatient Facility Services

Covered Services include benefits provided in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Facility,
- Mental health / substance use disorder Facility, or
- Other Facilities as approved.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Blood and blood products,
- Diagnostic services, and
- Therapy services.

Physical Therapy

Please see "Therapy Services".

Preventive Care

Preventive care is given during an office visit or as an outpatient service. Screenings and other services are covered for adults and children with no current symptoms or history of a medical condition associated with the screening service.

Persons who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit for that particular problem or condition.

Preventive care services will meet the requirements of federal and state law. Nearly all preventive care services are covered with no deductible, copayments or coinsurance when you use an in-network Provider. That means they are covered at 100% of the Maximum Allowed Amount. Covered Services fall under five broad groups:

1. Services for adults with an "A" or "B" rating from the United States Preventive Services Task Force [A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)]

which include Screening for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, Type 2 Diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use. Also includes counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention. Includes smoking and tobacco cessation products, including nicotine patches and gum when obtained with a prescription. Also covers aspirin and statins used to prevent cardiovascular disease.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents with an "A" or "B" rating from the U.S. Preventive Services Task Force and guidelines supported by the Health Resources and Services Administration including:

Assessments for alcohol and drug use, behavioral and oral health risk, medical history, and BMI measurements. Screenings for autism, infant hearing, anxiety, blood pressure, depression and suicide risk, development, dyslipidemia, hematocrit, or hemoglobin, hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, and vision. Also includes counseling for obesity and STI. Includes supplements for fluoride chemoprevention.

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, Preventive Guidelines and Screenings for Women, Children, and Youth | MCHB (hrsa.gov), including:

a. At least one form of women's contraception in each contraceptive category is covered without cost-sharing, as well as contraceptive services or FDA-approved, cleared, or granted contraceptive products that a woman and their attending provider have determined to be medically appropriate. This coverage also includes the clinical services, including patient education and counseling, needed for the provision of the contraceptive product or service, and items and services that are integral to the furnishing of the recommended preventive service, regardless of whether the item or service is billed separately.

b. Testing for Human Papillomavirus (HPV).

c. Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.

d. Urinary incontinence screening.

e. Screening and counseling for interpersonal and domestic violence.

f. Well woman visits.

g. Screening for pregnant women, gestational diabetes, hepatitis B, Rh incompatibility, and urinary tract or other infection.

h. Coverage for folic acid supplement.

i. Coverage for expanded tobacco intervention and counseling for pregnant users.

j. Breast feeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

k. Screening and counseling for BRCA risk assessment and genetic testing.

l. Breast cancer mammography.

m. Counseling for breast cancer chemoprevention.

n. Screening for cervical cancer and osteoporosis.

o. Diabetes screening after gestational diabetes.

5. Qualifying coronavirus preventive service, item or immunization intended to prevent or mitigate COVID-19, and that is:

- an item or service that has an A or B rating from the United State Preventive Services Task Force; or
- an immunization adopted by the Director of the Centers for Disease Control and Prevention.

You may view the federal government's web sites for more details about these services, Preventive health services | HealthCare.gov, A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org), and Preventive Guidelines and Screenings for Women, Children, and Youth | MCHB (hrsa.gov).

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services as required by state law:

- Routine screening mammograms
- Routine prostate specific antigen testing and digital rectal exams

Private Duty Nursing

Private Duty Nursing includes medically skilled services of a licensed RN or LPN in the home.

Minimum Requirement: 16 hours per Benefit Period.

Prosthetics

Please see "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies.".

Pulmonary Therapy

Please see "Therapy Services".

Radiation Therapy

Please see “Therapy Services”.

Rehabilitation and Habilitative Services

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, medical devices, and services of a social worker or psychologist. Also includes chiropractic/manipulation therapy.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary, and you stop progressing toward those goals.

Minimum Requirements:

- Rehabilitative Physical and Occupational therapy - 30 visits per Benefit Period, combined.
- Rehabilitative Speech therapy - 30 visits per Benefit Period.
- Rehabilitative chiropractic/manipulation therapy - 30 visits per Benefit Period

Visit limits do not apply when rehabilitative services are received for a mental health condition or substance use disorder.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age, or to teach coping strategies for social interaction. These services may include physical and occupational therapy, speech-language pathology, medical devices, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings. Also includes chiropractic/manipulation therapy.

Minimum Requirements:

- Habilitative physical and occupational therapy - 30 visits per Benefit Period, combined.
- Habilitative speech therapy - 30 visits per Benefit Period.
- Habilitative chiropractic/manipulation therapy - 30 visits per Benefit Period.

Visit limits do not apply when habilitative services are received for a mental health condition or substance use disorder.

Respiratory Therapy

Please see “Therapy Services.”.

Skilled Nursing Facility

When you require Covered Services for Medically Necessary Inpatient skilled nursing and related services for convalescent and rehabilitative care, these services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. The following items and services are covered for Inpatient care in a skilled nursing bed of a Skilled Nursing Facility:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other Medically Necessary services and supplies.

Covered Services include the private room charge if Medically Necessary. Otherwise, Inpatient benefits cover the Skilled Nursing Facility's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your copayment and coinsurance (if any).

Minimum Requirement: 100 days per stay, as deemed Medically Necessary.

Exclusion: Custodial Care. (Benefit plans that exclude Custodial Care for treatment of mental health conditions or substance use disorders will need to be able to demonstrate MHPAEA compliance, as applicable.)

Smoking Cessation

Please see "Preventive Care" and "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy".

Speech Therapy

Please see "Therapy Services".

Surgery

Covered Services include surgical services on an Inpatient or outpatient basis, including office surgeries, and:

- Operative and cutting procedures;
- Procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal looking appearance, other than orthognathic surgery;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and services rendered by an anesthesiologist and surgical support when Medically Necessary;

- Medically Necessary pre-operative and post-operative care;
- Surgical assistant; and
- Coverage for blood and blood products.

Important Note About Hysterectomy Admissions: Hospital admissions for a covered laparoscopy assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

Oral Surgery

Important Note: Although Covered Services include certain oral surgeries, many oral surgeries (e.g., removal of wisdom teeth) are not covered, except as provided below.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in "Dental Services (All Members / All Ages)".
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed at the same time of a mastectomy or following a mastectomy to establish symmetry. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service.

Note: This section does not apply to orthognathic surgery. Please see "Oral Surgery" for that benefit.

Mastectomy Notice

Covered Services include the following for persons who are receiving benefits for a mastectomy or for follow-up care for a mastectomy and who choose to have breast reconstruction:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance;
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Important Note About Mastectomy Admissions: Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours.

Telemedicine

The plan covers interactive Telemedicine services, which is the use of audio, video or other electronic media used for the purpose of diagnosis, consultation, or treatment, including remote patient monitoring, as it pertains to the delivery of covered health care services. Telemedicine services do not include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.

Exclusion: Fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Covered Services include coverage for the therapy services described below. Coverage for these Covered Services is described more completely under Rehabilitation Services and Habilitative Services. Covered Services include:

- **Physical therapy** – The treatment by a licensed practitioner to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes, but is not limited to, hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles, and devices, as well as treatment of lymphedema.

- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy necessary to teach speech. Therapy to develop communication or swallowing skills to correct a speech impairment.

- **Occupational therapy** – Treatment to restore a person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job.

- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

- **Exclusion:** Spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

Early Intervention Services
Please see "Early Intervention Services.".

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support after a cardiac event (heart problem).
    - **Exclusion:** Home programs, other than home care services, on-going conditioning, or maintenance care.

- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents administered as part of a Doctor's visit, home care visit, or at an outpatient facility. Please see the section "Prescription Drugs" for more details.

- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility or Doctor's office. Covered Services also include home dialysis, home equipment, supplies and training for you and the person who will help you with home self-dialysis.

- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered by a health care provider through an IV as part of a Doctor's visit, in your home as a home care visit, or at an outpatient Facility. Also includes blood products, total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections that are not self-administered (intra-muscular, subcutaneous, continuous subcutaneous). Please see the section "Prescription Drugs" for more details.

- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore health after an illness or injury.

- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, and treatment planning.

- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical

gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho pulmonary drainage and breathing exercises.

Transplant Services

Please see "Human Organ and Tissue Transplant.".

Urgent Care Services

Often an urgent, rather than an Emergency, health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an emergency room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- Office visit
- X-ray services
- Care for broken bones
- Tests such as flu, urinalysis, pregnancy test, rapid strep
- Lab services, including allergy testing
- Allergy shots/injections
- Medical supplies
- Advanced diagnostic imaging
- Surgery
- Prescription drugs
- Stitches for simple cuts
- Draining an abscess

Vision Services for Members Under Age 19

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

Routine Eye Exam

Covered Services include a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

Covered Services also include a choice of eyeglass lenses, including polycarbonate and photochromic lenses. Benefits include factory scratch coating and UV coating.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

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

- Progressive

Frames

A selection of frames is covered.

Minimum Requirement:
- One Frame per Benefit Period.

Contact Lenses

Covered Services include the following benefits for contact lenses:

- Elective Contact Lenses (Conventional or Disposable) – Contacts chosen for comfort or appearance; and
- Non-Elective Contact Lenses – Only for the following medical conditions:
  - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
  - High ametropia exceeding -12D or +9D in spherical equivalent.
  - Anisometropia of 3D or more.
  - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Exclusion: Benefits are not available for non-elective contact lenses if the covered person has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Minimum Requirement: Covered Services include only a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits include the cost of prescribed glasses or contact lenses when required as a result of surgery, or for the treatment of accidental injury. Services include the cost of materials and fitting, exams and replacement of these eyeglasses or contact lenses will be covered only if related to the surgery or injury. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations.
  - contact lenses are used for the treatment of infantile glaucoma;
  - corneal or scleral lenses are prescribed in connection with keratoconus;

- scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
- corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

III. Prescription Drugs

Prescription Drugs Administered by a Medical Provider

Covered Services include Prescription Drugs when they are administered as part of a Doctor's visit, home care visit, or at an outpatient Facility. This includes drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. Medically Necessary Formula and Enteral Nutrition Products prescribed or ordered by a qualified health care professional to manage an Inherited Metabolic Disorder by means of oral intake or enteral feeding by tube, as managed by a medical professional in a setting that includes a home setting. Coverage will include medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products. This section applies when your Provider orders the drug and administers it to you. Benefits for drugs that you inject or get at a Pharmacy (i.e., self-administered injectable drugs) are not covered under this section. Benefits for those drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important: Specific Prescription Drugs may have quantity and/or age limits or other limiting features such as prior authorization or step therapy, where you may need to use one type of drug before another will be approved.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Covered Services include benefits for Prescription Drugs you get at a Retail, Mail Order or Specialty Pharmacy. Prescriptions must be based on recognized and appropriate doses. The benefit will be managed to check for drug interactions or pregnancy concerns.

Access to Prescription Drug benefits from in-network retail Pharmacies is required, unless: (i) the Drug is subject to restricted distribution by the United States Food and Drug Administration (USFDA); or (ii) Special handling, provider coordination, or patient education is required for the drug and cannot be provided by a retail Pharmacy.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., Doctor's office, home care visit, or outpatient Facility) are covered under "Prescription Drugs". Please read that section for important details.

Prescription Drug Benefits

As stated in the "Prescription Drugs" section, Prescription Drug benefits may depend on reviews to decide when drugs should be covered. These reviews may include prior authorization, step therapy, use of a Prescription Drug List, therapeutic substitution, day/supply limits, and other utilization reviews. Your in-network Pharmacist will be told of any rules when you fill a prescription and will be also told about any details needed to decide benefits.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the USFDA and, under federal law, require a prescription. Prescription Drugs must be prescribed by a licensed Provider, and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription legend drugs from either a retail Pharmacy or the PBM's home delivery Pharmacy.
- Specialty Drugs.
- Self-administered injectable drugs. These are drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs" benefit.
- Self-injectable insulin and supplies and equipment used to administer insulin.
- Self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Contraceptives generally are covered under the "Preventive Care" benefit. Please see that section for more details. This includes Coverage for office visits associated with contraceptive management. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a covered person by a Provider or Pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies.
- Special food products or supplements when prescribed by a qualified health care professional and Medically Necessary. Medically Necessary Formula and Enteral Nutrition Products prescribed or ordered by a qualified health care professional to manage an Inherited Metabolic Disorder by means of oral intake or enteral feeding by tube, as managed by a medical professional in a setting that includes a home setting. Coverage will include medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products.
- Flu Shots (including administration).
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These drugs will be covered under the "Preventive Care" benefit.
- Smoking cessation products and over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription. These products will be covered under the "Preventive Care" benefit.

Prescription drugs (or Inpatient or IV therapy drugs) used in the treatment of cancer pain will not be denied on the basis that the dosage exceeds the recommended dosage of the pain-relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Benefits will not be denied for any drug approved by the USFDA to treat (i) cancer because the drug has not been approved by the USFDA for that specific type of cancer for which the drug has been prescribed, or (ii) a covered indication if the drug has been approved by the USFDA for at least one indication, if the drug is recognized in standard reference compendia as safe and effective for treatment of that specific type of cancer, or that covered indication, respectively.

Medically Necessary Formula and Enteral Nutrition Products

The plan covers any liquid or solid formulation of formula and enteral nutrition products for covered persons requiring treatment for an Inherited Metabolic Disorder and for which the covered person's Physician has issued a written order stating that the formula or enteral nutrition product is Medically Necessary and has been proven effective as a treatment regimen for the covered person and that the formula or enteral nutrition product is a critical source of nutrition as certified by the Physician by diagnosis. The Medically Necessary formula or enteral products do not need to be the covered person's primary source of nutrition. Inherited Metabolic Disorder means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Medically Necessary formula and enteral nutrition products are covered as medicine on the same terms and subject to the same conditions imposed on other medicines covered under the plan.

This coverage shall:

- Apply to the partial or exclusive feeding of a covered person by means of oral intake or enteral feeding by tube; and
- Include coverage for any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products; and
- Apply only when the formula and enteral nutrition products are:
  - furnished pursuant to the prescription or order of a Physician or other health care professional qualified to make such prescription or order for the management of an Inherited Metabolic Disorder; and
  - used under medical supervision, which may include a home setting.
- Not apply to nutritional supplements taken electively.

IV. Pediatric Dental Benefits (under age 19)

Covered Services include:

Preventive and Diagnostic Dental Care

- **Oral Exams**
  Minimum Requirement: One routine oral evaluation per 6 months, beginning with the eruption of the first tooth.

- **X-Rays**

- **Diagnostic Casts**

Basic Dental Care

- **Cleanings**
  Minimum Requirement: Once every 6 months.

- **Topical Fluoride Treatments**
  Minimum Requirement: Once every 6 months.

- **Sealants**
  Minimum Requirement: One per lifetime per tooth.

- **Space Maintainers**
  Minimum Requirement: One per 2 years per quadrant (unilateral), per arch (bilateral).

Restorative Dental Care

- **Fillings**
  Minimum Requirement: One per tooth per surface year.

- **Porcelain/Ceramic Onlay**
  Minimum Requirement: One per tooth per 5 years.

- **Crowns**
  Minimum Requirement: One per tooth per 5 years.

- **Protective Restorations**

- **Veneers**
  Minimum Requirement: One per tooth per 5 years

- **Temporary Crowns**

Major Dental Care

- **Endodontic Services**

    - Pulp Caps, Pulpotomy, Pupal therapy, and Pupal Debridement

    - Endodontic Therapy, Retreatment of Previous Root Canal
      Minimum Requirement: One per tooth per lifetime.

    - Apicoectomy/Retrograde Filling
      Minimum Requirement: One per tooth per lifetime.

- **Periodontal services**

    - Gingivectomy or Gingivoplasty
      Minimum Requirement: One per two years per quadrant.

    - Scaling and Root Planning
      Minimum Requirement: One per two years per quadrant.

    - Full Mouth Debridement
      Minimum Requirement: One per year.

    - Osseous Surgery
      Minimum Requirement: One per five years per quadrant.

    - Provision Splinting

    - Grafting

- **Removable Prosthodontics**
  Minimum Requirement: One per five years

    - Adjust, repair

    - Reline Denture
      Minimum Requirement: One per tooth per two years.

    - Tissue conditioning

- **Maxillofacial Prosthetics (feeding aid)**

- **Fixed Prosthodontics** – Pontic, Retainer, Crown
  Minimum Requirement: One per tooth per 5 years

Oral and Maxillofacial Surgery

- **Local Anesthesia**

- **Extractions,** including erupted wisdom teeth for symptomatic conditions to include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

- **Tooth Reimplantation and/or Stabilization due to accident**

- **Biopsy**

- **Alveoloplasty**
  Minimum Requirement: One per quadrant per lifetime.

- **Removal of Cysts, Tumors, and Growths**

- **Drainage of Abscess**

- **Occlusal Orthotic Device for TMJ**

- **Frenulectomy/Frenuloplasty**
  Minimum Requirement: One per lifetime.

Medically Necessary Orthodontia

- **Comprehensive Orthodontia**
  Minimum Requirement: One per lifetime.

- **Removable Appliance Therapy,** including appliances for thumb sucking and tongue thrusting.

- **Fixed Appliance Therapy,** including appliances for thumb sucking and tongue thrusting.
  Minimum Requirement: One per lifetime.

- **Replacement of Lost or Broken Retainer**

Adjunctive Services

- **Palliative (emergency pain) treatment**

- **Anesthesia/Sedation**

- **Occlusal Guard** (for grinding and clenching of teeth)

V. What's Not Covered

In this section you will find a review of items that are not covered by this plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by this plan.

Your carrier has the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered.

1) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond a carrier's control, the carrier will make a good faith effort to give you Covered Services. However, there may be a delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

   a) Acupuncture,
   b) Holistic medicine,
   c) Homeopathic medicine,
   d) Hypnosis,
   e) Aroma therapy,
   f) Massage and massage therapy,
   g) Reiki therapy,
   h) Herbal, vitamin or dietary products or therapies,
   i) Naturopathy,
   j) Thermography,
   k) Orthomolecular therapy,
   l) Contact reflex analysis,
   m) Bioenergial synchronization technique (BEST),
   n) Iridology-study of the iris,
   o) Auditory integration therapy (AIT),
   p) Colonic irrigation, and
   q) Neurofeedback / Biofeedback.

Note to Carriers: Benefit plans that exclude these coverages will need to be able to demonstrate MHPAEA compliance with NQTL comparative analysis, as applicable.

4) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in the plan.

5) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

6) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

7) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by the plan. Directly related means that the care took place as a direct result of a non-Covered Service and would not have taken place without the non-Covered Service.

8) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look for reasons other than for Medical Necessity.

This Exclusion does not apply to:

a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
b) Surgery or procedures to correct congenital abnormalities that cause functional impairment.
c) Surgery or procedures on newborn children to correct congenital abnormalities
d) Medically Necessary benefits determined according to nondiscriminatory criteria that are consistent with current medical standards.

9) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

10) **Custodial Care** Custodial Care, convalescent care or rest cures, this Exclusion does not apply to Hospice Care.

Note to Carriers: Benefit plans that exclude these coverages will need to be able to demonstrate MHPAEA compliance, as applicable.

11) **Dental Treatment** Dental treatment, except as listed below.

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X rays, supplies, appliances, and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth.
- Medical care or surgery for dental problems (unless listed as a Covered Service).
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded. This Exclusion does not apply to services that we must cover by law.

12) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as covered as a habilitative Services under the plan. Applied Behavior Analysis is not an educational service.

13) **Experimental or Investigational Services** Services or supplies that we find are Experimental/Investigational. This also applies to services related to Experimental/Investigational services, whether you get them before, during, or after you get the Experimental/Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it a Covered Service.

Please read the Experimental/Investigational definition in the "Definitions" section for the criteria used in deciding whether a service is experimental or investigative.

14) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in the plan. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.

15) **Eye Exercises** Orthoptics and vision therapy.

16) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

17) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

18) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

a) Cleaning and soaking the feet.
b) Applying skin creams to care for skin tone.
c) Other services that are given when there is not an illness, injury or symptom involving the foot.

Exclusion: This Exclusion does not apply to the treatment of corns, calluses, and care of toenails when services are Medically Necessary.

19) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless Medically Necessary.

20) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

21) Free Care Services you would not have to pay for if you didn't have the plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from workers compensation, and services from free clinics.

If workers' compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

22) Hearing Aids Hearing aids or exams to prescribe or fit hearing aids. This Exclusion does not apply to cochlear implants.

23) Health Club Memberships and Fitness Services Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

24) Home Care

a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

b) Food, housing, homemaker services and home delivered meals.

25) Infertility Treatment Treatment related to infertility.

26) Medical Equipment and Supplies

a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
c) Non-Medically Necessary enhancements to standard equipment and devices.

27) Medicare For which benefits are payable under Medicare Parts A, B, and/or D.

28) Missed or Cancelled Appointments Charges for missed or cancelled appointments.

29) Non-interactive Telemedicine Non-interactive Telemedicine services, such as audio-only telephone conversations; electronic mail message or fax transmissions.

30) Non-Medically Necessary Services Services that are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

31) Nutritional or Dietary Supplements Nutritional and/or dietary supplements, except as described in this plan. This Exclusion includes, but is not limited to, dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.

32) Oral Surgery Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except covered.

33) Personal Care and Convenience

a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
c) Home workout or therapy equipment, including treadmills and home gyms,
d) Pools, whirlpools, spas, or hydrotherapy equipment.
e) Hypo-allergenic pillows, mattresses, or waterbeds,
f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

34) Private Duty Nursing Private duty nursing received in the Inpatient setting.

35) Prosthetics Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics, except as specifically covered.

36) Providers Services you get from a non-covered Provider, as defined in this plan. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians.

Note to carriers: Benefit plans that exclude certain providers may need to be able to demonstrate MHPAEA compliance, as applicable.

37) Sexual Dysfunction Services or supplies for treatment of male or female sexual problems.

38) Stand-By Charges Stand-by charges of a Doctor or other Provider.

39) Sterilization Services to reverse elective sterilization

40) Surrogate Mother Services Services or supplies for a person not covered under the plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

41) Temporomandibular Joint Treatment Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

42) Travel Costs Mileage, lodging, meals, and other Member-related travel costs except as described in the plan.

43) Vein Treatment Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

44) Vision Services

a) Vision services for Members age 19 or older, unless listed as covered in the plan.

b) Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this plan.
c) Safety glasses and accompanying frames.
d) For two pairs of glasses in lieu of bifocals.
e) Plano lenses (lenses that have no refractive power)
f) Lost or broken lenses or frames if the person has already received benefits during a Benefit Period.
g) Vision services not listed as covered.
h) Cosmetic lenses or options.
i) Blended lenses.
j) Oversize lenses.
k) Sunglasses and accompanying frames.
l) For services or supplies combined with any other offer, coupon or in-store advertisement.
m) For Members to age 19, no benefits are available for frames not on the formulary.
n) Certain frames in which the manufacturer imposes a no discount policy.

45) Weight Loss Programs Programs, whether or not under medical supervision, unless listed as covered in this plan. This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

46) Weight Loss Surgery Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery, other gastric bypass surgery, Gastroplasty, or gastric banding procedures.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any drug except for approved covered immunizations.
2. **Compound Drugs** Compound drugs unless there is at least one ingredient that you need a prescription for, and the drug is not essentially a copy of a commercially available drug product.
3. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
4. **Delivery Charges** Charges for delivery of Prescription Drugs.
5. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the prescription order is issued. This includes samples given by a Doctor. This Exclusion does not apply to drugs used with a diagnostic service, drugs given during chemotherapy in the office as described in the "**Prescription Drugs**" section or drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
6. **Drugs Not on the Prescription Drug List (a formulary)**
7. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
   This Exclusion does not apply to over-the-counter drugs the plan must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
8. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the quantity limits set by the plan, or which are over any age limits set by us.
9. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
10. **Fluoride Treatments** Topical and oral fluoride treatments.
11. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
12. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
13. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend drugs, are covered as medical supplies based on where you get the service or item. Over the counter drugs, devices or products, are not Covered Services unless federal law requires coverage.
14. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.

15. **Lost or Stolen Drugs** Refills of lost or stolen drugs.
16. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any mail order Provider other than the PBM's Home Delivery Mail Order Provider, unless required by law.
17. **Non-approved Drugs** Drugs not approved by the FDA.
18. **Off label use** Off label use, unless coverage is required by law or if the carrier, or the PBM, approve it.
19. **Onychomycosis Drugs** Drugs for Onchomycosis (toenail fungus) unless Medically Necessary.
20. **Over-the-Counter Items** Drugs, devices and products, or prescription legend drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product. This includes prescription legend drugs when any version or strength becomes available over the counter.
    This Exclusion does not apply to over-the-counter products required under federal law with a Prescription.
21. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
22. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
23. **Weight Loss Drugs** Any drug mainly used for weight loss.

VI. Definitions

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in the plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:
1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Applied Behavior Analysis

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder

Any pervasive developmental disorder, or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association**.**

Benefit Period

The length of time benefits are covered. For calendar year plans, the Benefit Period starts on January 1st and ends on December 31st. For plan year plans, the Benefit Period starts on the group's effective or renewal date and lasts for 12 months. If a person's coverage ends before the end of the year, then the Benefit Period also ends.

Covered Services

Health care services, supplies, or treatment described in the plan that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental/Investigational, excluded, or limited.

- Approved before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post- Hospital Skilled Nursing Facility care; and (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Doctor

Please see “Physician (Doctor)”

Effective Date

The date your coverage begins under this plan.

Exclusions

Health care services your plan doesn’t cover.

Experimental/Investigational

Means any service or supply that is judged to be experimental or investigative at the carrier's sole discretion. Nothing in this Exclusion shall prevent a person from appealing the carrier's decision that a service is Experimental/Investigative. Services and supplies that are a part of an approved clinical trial will not be considered Experimental/Investigative. Services which do not meet each of the following criteria will be excluded from coverage as Experimental/Investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

   - This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:

     - the following three standard reference compendia defined below:
       - American Hospital Formulary Service - Drug Information
       - National Comprehensive Cancer Network's Drugs & Biologics Compendium
       - Elsevier Gold Standard's Clinical Pharmacology

     - in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

   - In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

   Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.

3. The available scientific evidence must show a good effect on health outcomes outside a research setting.

4. The service or supply must be as safe and effective outside research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered Experimental/Investigative.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by a carrier.

Gender Identity

An individual's internal sense of gender, which may be male, female, neither, or a combination of male and female and which may be different from an individual's sex assigned at birth.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. room, board, and nursing care; and
2. a staff with one or more Doctors on hand at all times; and
3. 24-hour nursing service; and
4. all the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. Custodial Care
6. educational care
7. subacute care

Inherited Metabolic Disorder

An inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Maximum Allowed Amount

The maximum payment that the carrier will allow for Covered Services.

Medical Necessity (Medically Necessary)

To be considered Medically Necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition; and
- be consistent with the symptoms or diagnosis and treatment of your condition; and
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider.

Medically Necessary Formula and Enteral Nutrition Products

Any liquid or solid formulation of formula and enteral nutrition products for covered individuals requiring treatment for an Inherited Metabolic Disorder and for which the covered individual's physician has issued a written order stating that the formula or enteral nutrition product is Medically Necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis. The Medically Necessary formula or enteral products do not need to be the covered individual's primary source of nutrition.

Medically Necessary Transition-related Care

Any medical treatment prescribed by a licensed physician for treatment of gender dysphoria and includes (i) outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses; (ii) continuous hormone replacement therapy; (iii) outpatient laboratory testing to monitor continuous hormone therapy; and (iv) gender reassignment surgeries.

MHPAEA

The federal Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343

Member

People, including the Subscriber and dependents, who have met the eligibility rules, applied for coverage, and enrolled in the plan.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor,
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Prescription Drug

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription."

This includes the following:

1) Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.

2) Insulin, diabetic supplies, and syringes.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider required by state law to be covered.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major Pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate

agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us.

A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury; and
2. Care supervised by a Doctor; and
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency, or a place for rest, educational, or similar services.

Specialist

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail Pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Stabilize

With respect to an Emergency Medical Condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

Subscriber

A person who is eligible for, has enrolled in the plan, and is the policyholder.

Telemedicine

Means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine services do not include audio-only telephone conversation, electronic mail message or facsimile transmission.

Transgender Individual

An individual whose Gender Identity is different from the sex assigned to that individual at birth.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.