Benefits for Healthcare Coverage

# The North Dakota Benchmark Plan

The North Dakota Benchmark Plan serves as a baseline for the minimum scope of benefits that most health plans sold in the individual and small group markets must cover at equal or greater value.

Since the inception of the ACA, federal guidance has allowed each state the opportunity to select their benchmark from 10 possible plans:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market;
- Any of the largest three state employee health benefit plan options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment;
- The Health Maintenance Organization (HMO) plan with the largest insured commercial non-Medicaid enrollment in the state.

Further, the Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in ten benefit categories. HHS regulations (45 CFR 156.100) define EHB based on state specific EHB benchmark plans, which apply to individual and small group ACA compliant plants. For plan year 2020 and after, the Final 2019 HHS Notice of Benefits and Payment Parameters provides states with greater flexibility by establishing standards for States to update their EHB benchmark plans. CMS is providing States three new options for selection starting in plan year 2020, including:

- Option 1: Selecting the EHB-benchmark plan that another State used for the 2017 plan year.
- Option 2: Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year.
- **Option 3: Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.**

The North Dakota Insurance Department (DOI) is utilizing the greater flexibility granted by CMS in **Option 3** to update their EHB benchmark plans to cover all the benefits included in the current EHB-BP, except that it would limit cost sharing for insulin/insulin supplies; add coverage for hearing aids and PET scans; and expand coverage for nutritional counseling (include coverage for the use of GLP1 and GIP drugs), periodontal disease, and opioid benefits.

North Dakota's current EHB Benchmark, was adopted as the Blue Cross Blue Shield of North Dakota small group exchange plan, BlueCare Gold 90 500 beginning in 2017. The additional flexibility granted in the 2019 Notice of Benefit and Payment Parameters (NBPP) has allowed North Dakota an opportunity to review other possible options to ensure a strong benefit design for consumers and increased stability in the comprehensive healthcare insurance market.

This attached actuarial certification and associated actuarial report affirm that the State's EHB-BP:

Provides a scope of benefits that is equal to, or greater than, the extent any supplementation is required to provide coverage within each EHB category at 45 CFR 156.110(a), the scope of benefits provided under a typical employer plan ("Typical Employer Plan"), as defined at 45 CFR 156.111(b)(2)(i), and

Does not exceed the generosity of the most generous small group plans among the plans ("Comparison Plans") listed at 45 CFR 156.111(b)(2)(ii)(A) and (B). This set of comparison plans for purposes of the generosity standard includes the State's EHB-BP used for the 2017 plan year, and any of the State's base-

benchmark plan options used for the 2017 plan year described in 45 CFR 156.100(a)(1), supplemented as necessary under 45 CFR 156.110.

North Dakota has chosen to use Option 3 in its approach to a new EHB benchmark designation. The actuarial study by NovaRest is accompanying this submission details the plan analysis completed and certifies the proposed changes fall within the establish generosity test parameters.

The actuarial study found that The Federal Employee Health Benefits Standard Plan (FEHBP) administered by Blue Cross Blue Shield of North Dakota was one of the ten base-benchmark plan options for North Dakota's 2017 plan year EHB selection and represents both a Typical Employer Plan and a Comparison Plan. The proposed EHB-BP includes the same categories of benefits as the FEHBP (which represents a Typical Employer Plan), and therefore we believe the scope of benefits of the proposed EHB benchmark plan is at least equal to that of a Typical Employer Plan.

**SECTION 1**
**MINIMUM BENEFITS**

| Covered Services | Provider of Service: In-Network After Deductible Amount | Provider of Service: Out-of-Network After Deductible Amount |
|---|---|---|
| **Inpatient Hospital and Medical Services** | | |
| • Inpatient Hospital Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Inpatient Medical Care Visits | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Ancillary Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Inpatient Consultations | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Concurrent Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Initial Newborn Care | 90% of Allowed Charge. | 70% of Allowed Charge. |
| **Inpatient and Outpatient Surgical Services** | | |
| • Professional Health Care Provider Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Assistant Surgeon Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Ambulatory Surgical Facility Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Hospital Ancillary Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Anesthesia Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Morbid Obesity Surgery | 90% of Allowed Charge. Benefits are subject to a Lifetime Maximum of 1 operative procedure per Consumer when Prior Approval is received from INSURER. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| | 100% of Allowed Charge. Deductible Amount is waived. | |
| • Outpatient Sterilization Procedures for Females | | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| **Transplant Services** | | |
| • Inpatient and Outpatient Hospital and Medical Services | 90% of Allowed Charge when Prior Approval is received from INSURER.<br><br>Covered Services must be received from a transplant facility approved by INSURER. | **No Coverage.** |
| **Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment** | 90% of Allowed Charge. | 70% of Allowed Charge. |
| | Benefits are subject to a Lifetime Maximum of 2 surgical procedures per Consumer and a Maximum Benefit Allowance of 1 splint per Consumer per Benefit Period. | |
| **Outpatient Hospital and Medical Services** | | |
| • Home and Office Visits | $15 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| • Diagnostic Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Emergency Services (See Section 8, Definitions) | $50 Copayment Amount for emergency room facility fee billed by a Hospital, then 100% of Allowed Charge. Deductible Amount is waived.<br><br>$15 Copayment Amount for office or emergency room visit billed by a Professional Health Care Provider, then 100% of Allowed Charge. Deductible Amount is waived.<br><br>90% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office. In-Network Deductible Amount applies. | |
| • Urgent Care Services at Urgent Care Center or Facility | $15 Copayment Amount, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| • Dental Services Related to Accidental Injury | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Preadmission Testing Services | | |
| Diagnostic Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| Related Office Visit | $15 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | |
| • Diagnosis and Treatment of Periodontal Disease | 50% of Allowed Charge. | **NO COVERAGE.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| • Second Surgical Opinions | | |
| Diagnostic Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| Related Office Visit | $15 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| • Radiation Therapy and Chemotherapy | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Dialysis Treatment | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Home Infusion Therapy Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Allergy Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Phenylketonuria (PKU) – Foods and food products for the dietary treatment of Consumers born after 12/31/62 with phenylketonuria | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Amino Acid-Based Elemental Oral Formulas | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Dental Anesthesia and Hospitalization | 90% of Allowed Charge. Prior Approval is required for all Consumers age 9 and older. | 70% of Allowed Charge. Prior Approval is required for all Consumers age 9 and older. |
| **Wellness Services** | | |
| • Well Child Care to the Consumer's 6th birthday | 100% of Allowed Charge. Deductible Amount is waived.<br>Including:<br>• 7 visits for Consumers from birth through 12 months;<br>• 4 visits for Consumers from 13 months through 35 months;<br>• 1 visit per Benefit Period for Consumers.36 months through 72 months | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| • Immunizations | 100% of Allowed Charge. Deductible Amount is waived.<br><br>Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease, Influenza Virus, Tetanus, Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply. | **No Coverage.** |
| • Preventive Screening Services for Consumers age 6 and older | Benefits are available for preventive screening services according to A or B Recommendations of the U.S. Preventive Services Task Force and issued by the Health Resources and Services Administration, Including: | |
| Routine Physical Examination (Office Visit) | 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| Routine Diagnostic Screenings:<br>➢ Adult Aortic Aneurysm Screening for male Consumers age 65 and older<br>➢ Lipid Disorders Screening once every 5 years<br>➢ Osteoporosis Screening for female Consumers once every 2 years<br>➢ Sexually Transmitted Disease (STD) Screening<br>➢ Diabetes Screening | 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| Mammography Screening | 100% of Allowed Charge. Deductible Amount is waived.<br><br>• One service for Consumers between the ages of 35 and 40;<br>• One service per year for Consumers age 40 and older. | **No Coverage.** |
| Cervical Cancer Screening | 100% of Allowed Charge. Deductible Amount is waived.<br><br>Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period. | **No Coverage.** |
| Related Office Visit | 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| Colorectal Cancer Screening for Consumers age 50 through 75: | | |
| ➢ Fecal Occult Blood Testing – subject to a Maximum Benefit Allowance of 1 test per Benefit Period; and | 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| ➢ Colonoscopy – subject to a Maximum Benefit Allowance of 1 test every 10 years; or | 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| ➢ Sigmoidoscopy – subject to a Maximum Benefit Allowance of 1 test every 5 years. | 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| Prostate Cancer Screening | 90% of Allowed Charge. Deductible Amount is waived.<br><br>Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for an asymptomatic male age 50 and older, a black male age 40 and older, and a male age 40 and older with a family history of prostate cancer. Coverage shall continue to be provided for PET scans based on medical necessity as an imaging benefit. A prostate cancer diagnoses is not a condition precedent to coverage. Upon initial prostate cancer diagnosis, at minimum, coverage shall be provided for two PET Scans (FDG, PSMA, Choline, etc.), if requested by a physician. Additional PET scans may be completed every six months for the life of the consumer, if requested by a physician. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| Related Office Visit | $15 Copayment Amount for the Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| Physical Therapy for community dwelling Consumers age 65 and older at risk for falls | 100% of Allowed Charge. Deductible Amount is waived.<br><br>A community dwelling Consumer is an individual who does not live in an assisted- living facility or nursing home. | **No Coverage.** |
| Dietary or Nutritional Screening, Counseling And/or Therapy, including but not limited to Nutritional or Weight Loss Programs | 100% of Allowed Charge. Deductible Amount is waived.<br><br>• Hyperlipidemia – Maximum Benefit Allowance of 12 visits per Consumer per Benefit Period.<br>• Gestational Diabetes – Maximum Benefit Allowance of 12 visits per Consumer per Benefit Period.<br>• Diabetes Mellitus – Maximum Benefit Allowance of 12 visits per Consumer per Benefit Period.<br>• Hypertension – Maximum Benefit Allowance of 12 visits per Consumer per Benefit Period.<br>• Obesity – Maximum Benefit Allowance of 12 visits per Consumer per Benefit Period.<br>• Other diabetes-related diagnosis or a chronic illness or condition – Maximum Benefit Allowance of 12 visits per Consumer per Benefit Period | **No Coverage.** |

Coverage shall also be provided for the use of GLP1 and GIP drugs (specifically semaglutide and tirzepatide) as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity.

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| • Outpatient Nutritional Care Services for PKU | $15 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| | Benefits are subject to a Maximum Benefit Allowance of 12 Office Visits per Consumer per Benefit Period. | |
| • Diabetes Education Services | 90% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| • Dilated Eye Examination (for diabetes related diagnosis) | $15 Copayment Amount, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| | Benefits are subject to a Maximum Benefit Allowance of 1 examination per Consumer per Benefit Period. | |
| • Tobacco Cessation Services<br>Prescription Non-Nicotine Replacement Therapy<br>Payable Over the Counter (OTC) Nicotine Replacement Therapy (nicotine lozenges, patches, gum)<br>Prescription Nicotine Replacement Therapy (nicotine nasal spray, inhaler, patches) | Tobacco cessation services obtainable with a Prescription Order are paid at 100% of the Allowed Charge. Deductible Amount is waived.<br>Benefits are subject to a Maximum Benefit Allowance of 2 quit attempt cycles per Consumer per Benefit Period. A quit attempt cycle includes 4 counseling visits and/or a 3- month supply of nicotine or non-nicotine replacement therapy. | **No Coverage.** |
| Related Office Visit | 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| **Outpatient Therapy Services** | | |
| • Physical Therapy | $15 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| | Rehabilitative and Habilitative Physical Therapy benefits are subject to a combined Maximum Benefit Allowance of 30 visits per Consumer per Benefit Period. | |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| • Occupational Therapy | $15 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| | Rehabilitative and Habilitative Occupational Therapy benefits are subject to a combined Maximum Benefit Allowance of 30 visits per Consumer per Benefit Period. | |
| • Speech Therapy | $15 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| | Rehabilitative and Habilitative Speech Therapy benefits are subject to a combined Maximum Benefit Allowance of 30 visits per Consumer per Benefit Period. | |
| • Other Therapy Services | | |
| Respiratory Therapy Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| Cardiac Rehabilitation Services | $15 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| | Benefits are subject to a Maximum Benefit Allowance of 30 visits per Consumer per episode. Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital. | |
| Pulmonary Rehabilitation Services | $15 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| | Benefits are subject to a Lifetime Maximum of 3 visits per Consumer. | |
| Vision Therapy | 90% of Allowed Charge. | 70% of Allowed Charge. |
| | Benefits are subject to a Maximum Benefit Allowance of 30 visits per Consumer per Benefit Period. | |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| **Chiropractic Services** | Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.<br><br>Benefits are subject to a Maximum Benefit Allowance of 20 visits per Consumer per Benefit Period. | |
| • Home and Office Visits | $15 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| • Therapy and Manipulation | $15 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| • Diagnostic Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| **Maternity Services** | | |
| • Inpatient Hospital and Medical Services | 90% of Allowed Charge. | 70% of Allowed Charge. |
| • Prenatal and Postnatal Care | 90% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. |
| • Lactation Counseling | 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| **Contraceptive Services** | 100% of Allowed Charge. Deductible Amount is waived. | 70% of Allowed Charge. 70% |
| • Related Office Visit | 100% of Allowed Charge. Deductible Amount is waived. | of Allowed Charge. |
| | Prescription contraceptive services obtainable with a Prescription Order are paid under the Outpatient Prescription Medications or Drugs benefit. | |
| **Psychiatric and Substance Abuse Services** | | |
| • Psychiatric Services | | |
| Inpatient | 90% of Allowed Charge. Preauthorization is required. | 70% of Allowed Charge. Preauthorization is required. |
| Residential Treatment for Consumers under age 21 | 90% of Allowed Charge. Preauthorization is required. | 70% of Allowed Charge. Preauthorization is required. |
| Partial Hospitalization | 90% of Allowed Charge. Preauthorization is required. | 70% of Allowed Charge. Preauthorization is required. |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| Outpatient | 100% of Allowed Charge and Deductible Amount is waived for the initial 5 hours per Consumer per Benefit Period. | |
| | Covered Services received during the remainder of the Benefit Period are payable at 90% of Allowed Charge and are subject to the Deductible Amount. | Covered Services received during the remainder of the Benefit Period are payable at 70% of Allowed Charge and are subject to the Deductible Amount. |
| • Substance Abuse Services | | |
| Inpatient | 90% of Allowed Charge. Preauthorization is required. | 70% of Allowed Charge. Preauthorization is required. |
| Residential Treatment for Consumers under age 21 | 90% of Allowed Charge. Preauthorization is required. | 70% of Allowed Charge. Preauthorization is required. |
| Partial Hospitalization | 90% of Allowed Charge. Preauthorization is required. | 70% of Allowed Charge. Preauthorization is required. |
| Intensive Outpatient Program | 100% of Allowed Charge and Deductible Amount is waived for the initial 5 visits per Consumer per Benefit Period. Preauthorization is required. | |
| | Covered Services received during the remainder of the Benefit Period are payable at 90% of Allowed Charge and are subject to the Deductible Amount. Preauthorization is required. | Covered Services received during the remainder of the Benefit Period are payable at 70% of Allowed Charge and are subject to the Deductible Amount. Preauthorization is required. |
| Outpatient | 100% of Allowed Charge and Deductible Amount is waived for the initial 5 visits per Consumer per Benefit Period. | |
| | Covered Services received during the remainder of the Benefit Period are payable at 90% of Allowed Charge and are subject to the Deductible Amount. | Covered Services received during the remainder of the Benefit Period are payable at 70% of Allowed Charge and are subject to the Deductible Amount. |
| All fills of opioid prescriptions shall be limited to 7 days. Intranasal spray opioid reversal against shall be covered with a prescription for opioids at 50MME and higher. There shall be no prior authorization requirements for Buprenorphine and similar opioid replacement drugs. | | |
| **Ambulance Services** | 90% of Allowed Charge. | 90% of Allowed Charge subject to the In-Network Deductible Amount. |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| **Skilled Nursing Facility Services** | 90% of Allowed Charge.<br><br>Benefits are subject to a Maximum Benefit Allowance of 30 days per Consumer per Benefit Period. | 70% of Allowed Charge. |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| **Home Health Care Services** | 90% of Allowed Charge.<br><br>Benefits are subject to a Maximum Benefit Allowance of 40 visits per Consumer per Benefit Period. A visit is considered up to 4 continuous hours. | 70% of Allowed Charge. |
| **Hospice Services** | 90% of Allowed Charge. | 70% of Allowed Charge. |
| **Medical Supplies and Equipment**<br><br>• Home Medical Equipment<br>• Orthotic Devices<br>• Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Outpatient Prescription Medications or Drugs<br>• Oxygen Equipment and Supplies<br>• Ostomy Supplies<br>• Prosthetic Appliances and Limbs | 90% of Allowed Charge.<br><br>Prior Approval is required. | 70% of Allowed Charge.<br><br>Prior Approval is required. |
| **Breast Pumps** | 100% of Allowed Charge. Deductible Amount is waived.<br><br>Benefits are available for the rental or purchase of 1 breast pump per pregnancy. | **No Coverage.** |
| **Pediatric Dental Services for Consumers under age 19** | | |
| Category 1 – Diagnostic | | |
| A. Routine oral evaluations allowed twice during a Benefit Period. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| B. Bitewing X-rays allowed once during a Benefit Period, except when part of a full mouth survey. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| C. Full mouth survey allowed once every 3 years. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| D. Panoramic film is allowed once every 3 years. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| E. Intraoral periapical X-rays. | 50% of Allowed Charge. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| Category 2 – Preventive | | |
| A. Prophylaxis allowed 4 times during a Benefit Period. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| B. Topical Fluoride applications allowed twice during a Benefit Period. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| C. Sealants on unfilled, undecayed permanent molars and bicuspids. Benefits are limited to a Lifetime Maximum of 2 sealants per tooth. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| D. Space maintainers. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| Category 3 – Restorative | | |
| A. Fillings (pin-retention - limit 2). | 50% of Allowed Charge. | **No Coverage.** |
| B. Inlays, onlays and Crowns (not part of a fixed partial Denture). Replacement of lost or defective inlays, onlays or Crowns is allowed once every 5 years. | 50% of Allowed Charge. | **No Coverage.** |
| C. Veneers other than cosmetic are allowed once every 5 years. | 50% of Allowed Charge. | **No Coverage.** |
| Category 4 – Endodontics | | |
| A. Pulpotomy, pulp capping, root canal therapy, apicoectomy, root amputation, hemi section, bleaching of endodontically treated anterior permanent teeth. | 50% of Allowed Charge. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| Category 5 – Periodontics | | |
| A. Surgical Periodontic evaluation once for each course of treatment. | 50% of Allowed Charge. | **No Coverage.** |
| B. Gingivectomy, Gingival Curettage, mucogingival surgery, osseous surgery. | 50% of Allowed Charge. | **No Coverage.** |

| | | |
|---|---|---|
| C. Diagnosis and Treatment of Periodontal disease when recommended by a board-certified medical practitioner based on health-related impacts or further deterioration in existing acute or chronic disease state due to gum disease, including but not limited to periodontal scaling and root planing. | 50% of Allowed Charge. | **No Coverage.** |

| **Covered Services** | **Provider of Service:** **In-Network After Deductible Amount** | **Out-of-Network After Deductible Amount** |
|---|---|---|
| Category 6 – Prosthodontics (removable) | | |
| A. Dentures (complete and partial). Replacement of lost or defective Dentures is allowed once every 5 years. | 50% of Allowed Charge. | **No Coverage.** |
| B. Tissue conditioning twice per treatment sequence for relining or for new or duplicate Dentures. | 50% of Allowed Charge. | **No Coverage.** |
| C. Relining of immediate Dentures once during the year after insertion. | 50% of Allowed Charge. | **No Coverage.** |
| D. Relining of complete and partial Dentures other than in item above, allowed once every 3 years. | 50% of Allowed Charge. | **No Coverage.** |
| Category 7 – Maxillofacial Prosthetics | **No Coverage.** | **No Coverage.** |
| Category 8 – Implant Services | **No Coverage.** | **No Coverage.** |
| Category 9 – Prosthodontics (fixed) | | |
| A. Fixed partial Denture. Replacement of lost or defective fixed partial Dentures is allowed once every 5 years. | 50% of Allowed Charge. | **No Coverage.** |
| Category 10 – Oral and Maxillofacial Surgery | | |
| A. Simple Extractions. | 50% of Allowed Charge. | **No Coverage.** |
| B. Surgical Extractions. | 50% of Allowed Charge. | **No Coverage.** |
| C. Oral Maxillofacial Surgery including fracture and dislocation treatment, frenulectomy and cyst and abscess diagnosis and treatment. | 50% of Allowed Charge. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| Category 11 – Orthodontics | | |
| A. The treatment of improper alignment of biting or chewing surfaces of upper and lower teeth through the installation of orthodontic appliances. Benefits are limited to a Lifetime Maximum of 1 orthodontic placement per Consumer. | 50% of Allowed Charge. Prior Approval is required. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| Category 12 – Adjunctive General Services | | |
| A. Palliative (emergency) treatment of dental pain. | $40 Copayment Amount per visit, then 100% of Allowed Charge. Deductible Amount is waived. | **No Coverage.** |
| B. Anesthesia services. | 50% of Allowed Charge. | **No Coverage.** |
| C. Occlusal guard for treatment of Bruxism allowed once every 3 years. | 50% of Allowed Charge. | **No Coverage.** |
| **Pediatric Vision Services for Consumers under age 19** | | |
| Vision Examinations | 90% of Allowed Charge.<br><br>Benefits Include refraction and glaucoma screening (tonometry test), subject to a Maximum Benefit Allowance of 1 examination per Consumer per Benefit Period. | **No Coverage.** |
| Prescribed Lenses and Frames | 90% of Allowed Charge.<br><br>Prescribed lenses are allowed once per Benefit Period.<br><br>Frames are allowed once every other Benefit Period.<br><br>Benefits are available for contact lenses in lieu of the prescribed frames and/or lenses benefit. | **No Coverage.** |
| **Eyeglasses or Contact Lenses** for Consumers diagnosed with aphakia | 90% of Allowed Charge.<br><br>Benefits are subject to a Lifetime Maximum of 1 pair of eyeglasses or contact lenses for Consumers diagnosed with aphakia. | 70% of Allowed Charge. |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| **Outpatient Prescription Medications or Drugs and Diabetes Supplies** | | |
| **Retail Pharmacy** | | |
| • Generic | $10 Copayment Amount, then 100% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. | **No Coverage.** |
| • Brand Name Formulary | $20 Copayment Amount, then 100% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. | **No Coverage.** |
| • Brand Name Nonformulary | $30 Copayment Amount, then 100% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. | **No Coverage.** |
| **Preferred Mail Order Pharmacy** | | |
| • Generic | $10 Copayment Amount, then 100% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. | **No Coverage.** |
| • Brand Name Formulary | $20 Copayment Amount, then 100% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. | **No Coverage.** |
| • Brand Name Nonformulary | $30 Copayment Amount, then 100% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. | **No Coverage.** |

| Covered Services | Provider of Service: In-Network After Deductible Amount | Out-of-Network After Deductible Amount |
|---|---|---|
| **Specialty Pharmacy** | | |
| • Generic | 90% of Allowed Charge. | **No Coverage.** |
| • Brand Name Formulary | 90% of Allowed Charge. | **No Coverage.** |
| • Brand Name Nonformulary | 90% of Allowed Charge. | **No Coverage.** |

**Copayment Amount Application:**

Formulary contraceptive drugs obtainable with a Prescription Order are paid at 100% of Allowed Charge. Copayment Amounts do not apply. Deductible Amount is waived.

Copayment Amount shall not exceed $25.00 for a 30-day supply of insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for the treatment of diabetes. Insulin includes but is not limited to the following categories: rapid-acting insulin, short-acting insulin, intermediate-acting insulin, long-acting insulin, premixed insulin product, premixed insulin/GLP-1 RA product, concentrated human regular insulin

Copayment Amounts do not apply to the following nonprescription diabetic supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions. The Copayment Amount shall not exceed $25.00 for prescribed medical supplies for insulin dosing and administration, regardless of the quantity or manufacturer of supplies. Prescribed medical supplies for insulin shall include but is not limited to blood glucose meters, blood glucose test strips, lancing devices and lancets, ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips, glucagon, injectable or nasal forms, insulin pen needles, and insulin syringes.

**Retail Pharmacy**
One Copayment Amount per Prescription Order or refill for a 1 – 30-day supply. Two Copayment Amounts per Prescription Order or refill for a 31 – 60-day supply. Three Copayment Amounts per Prescription Order or refill for a 61 – 90-day supply.

Copayment Amount shall not exceed $25.00 for a 30-day supply of insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for the treatment of diabetes. Insulin includes but is not limited to the following categories: rapid-acting insulin, short-acting insulin, intermediate-acting insulin, long-acting insulin, premixed insulin product, premixed insulin/GLP-1 RA product, concentrated human regular insulin

The Copayment Amount shall not exceed $25.00 for prescribed medical supplies for insulin dosing and administration, regardless of the quantity or manufacturer of supplies. Prescribed medical supplies for insulin shall include but is not limited to blood glucose meters, blood glucose test strips, lancing devices and lancets, ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips, glucagon, injectable or nasal forms, insulin pen needles, and insulin syringes.

**Preferred Mail Order Pharmacy**
Two Copayment Amounts per Prescription Order or refill for a 60 – 90-day supply.

Dispensing Limits:
Prescription Medications or Drugs and nonprescription diabetic supplies are subject to a dispensing limit of a 90-day supply. Specialty Drugs are subject to a dispensing limit of a 30-day supply.

Copayment Amount shall not exceed $25.00 for a 30-day supply of insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for the treatment of diabetes. Insulin includes but is not limited to the following categories: rapid-acting insulin, short-acting insulin, intermediate-acting insulin, long-acting insulin, premixed insulin product, premixed insulin/GLP-1 RA product, concentrated human regular insulin

The Copayment Amount shall not exceed $25.00 for prescribed medical supplies for insulin dosing and administration, regardless of the quantity or manufacturer of supplies. Prescribed medical supplies for insulin shall include but is not limited to blood glucose meters, blood glucose test strips, lancing devices and lancets, ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips, glucagon, injectable or nasal forms, insulin pen needles, and insulin syringes.

If a Generic Prescription Medication or Drug is the therapeutic equivalent for a Brand Name Prescription Medication or Drug and is authorized by a Consumer's Professional Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Consumer does not accept the Generic equivalent the Consumer is responsible for the cost difference between the Generic and the Brand Name Prescription Medication or Drug and applicable Cost Sharing Amounts.

## SECTION 2
## COVERED SERVICES

Benefits are available for Medically Appropriate and Necessary services, subject to the definitions, exclusions, conditions, and limitations.

### 2.1 INPATIENT HOSPITAL AND MEDICAL SERVICES

A. Inpatient Hospital Services include:

1. Bed, board, and general nursing services.

2. Special Care Units when Medically Appropriate and Necessary.

3. Long Term Acute Care Facility, Rehabilitation Facility or Transitional Care Unit when Medically Appropriate and Necessary.

4. Ancillary Services when Medically Appropriate and Necessary, Including:

   a. use of operating, delivery, and treatment rooms;
   b. prescribed drugs;
   c. blood, blood substitutes and the administration of blood and blood processing;
   d. anesthesia and related supplies and services provided by an employee of or a person under contractual agreement with a Hospital;
   e. medical and surgical dressings, supplies, casts, and splints;
   f. Diagnostic Services; and
   g. Therapy Services.

5. Dental anesthesia and hospitalization for dental care to Consumers under age 9, Consumers who are severely disabled or Consumers who have a medical condition that requires hospitalization or general anesthesia. Prior Approval is required for all Consumers age 9 and older.

B. Inpatient Medical Services include:

1. Inpatient medical care visits by a Professional Health Care Provider, except inpatient stays related to surgery or maternity care. See Section 2.2, Inpatient and Outpatient Surgical Services and Section 2.9, Maternity Services. Benefits are available for inpatient medical care visits for the treatment of mental illness or substance abuse only when provided in conjunction with a covered inpatient psychiatric or substance abuse Admission.

2. Consultation services by another Professional Health Care Provider at the request of the attending Professional Health Care Provider for the purpose of advice, diagnosis or instigation of treatment requiring special skill or knowledge. Benefits are available only if a written report from a consultant is a part of the Consumer's medical records. Consultation benefits do not include staff consultations required by hospital rules and regulations.

3. Concurrent services Including medical, surgical, maternity, Chemotherapy or Radiation Therapy provided during one inpatient stay by one Professional Health Care Provider. Benefits for concurrent services will be based on the Covered Service with the highest Allowance.

When two or more Professional Health Care Providers have attended the Consumer during one inpatient stay because the nature or severity of the Consumer's condition requires the skills of separate Professional Health Care Providers, benefits will be available for the Covered Service that carries the highest Allowance for the type of service provided by each Professional Health Care Provider, provided the service is Medically Appropriate and Necessary and would otherwise be a Covered Service under this Benefit Plan.

4. Routine nursery care and the initial inpatient examination of the newborn child by a Professional Health Care Provider if the newborn child is a Member. The newborn child is also entitled to benefits from the moment of birth for any illness, accident, deformity, or congenital conditions.

## 2.2 INPATIENT AND OUTPATIENT SURGICAL SERVICES

A. Inpatient Surgical Services include:

1. Surgical Services provided by a Professional Health Care Provider. Separate benefit payments will not be made for preoperative and postoperative services. Payment for these services is included in the surgical fee.

2. Assistant surgeon services by a Professional Health Care Provider who actively assists the operating surgeon in the performance of covered surgery if the type of surgery performed requires an assistant, as determined by INSURER, and no Hospital or Ambulatory Surgical Facility staff is available to provide such assistance.

3. Administration of Medically Appropriate and Necessary anesthesia for a covered surgical procedure when ordered by the attending Professional Health Care Provider and provided by or under the direct supervision of an Anesthesiologist or Professional Health Care Provider other than the operating surgeon or the assistant surgeon.

B. The benefits described above are also available for Outpatient Surgical Services in addition to:

1. Supplies used for a covered surgical procedure when performed in a Professional Health Care Provider's office, clinic, or Ambulatory Surgical Facility.

2. Facility charges for covered outpatient Surgical Services performed in an Ambulatory Surgical Facility.

3. Hospital Ancillary Services and supplies used for a covered outpatient surgery, Including removal of sutures, anesthesia and related supplies and services when provided by an employee of or under contractual agreement with the Hospital, other than the surgeon or assistant at surgery.

C. Benefits are available for the following special surgeries:

1. Reconstructive surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

Benefits include reconstructive breast surgery performed as a result of a partial or total mastectomy subject to Benefit Plan Cost Sharing Amounts. Benefits also include reconstructive breast surgery on the non-diseased breast to establish symmetry with the reconstructed diseased breast. Benefits for prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, are allowed under Section 2.16, Medical Supplies and Equipment. Benefits will be allowed in a manner determined in consultation with the attending Professional Health Care Provider and the Consumer.

Cosmetic surgery will not qualify as reconstructive surgery when performed for the treatment of a psychological or psychiatric condition.

2. Sterilization procedures. Procedures to evaluate and reverse sterilization are not covered under this Benefit Plan.

3. Surgery for morbid obesity after Prior Approval is received from INSURER. Covered Services must be received from a surgical facility approved by INSURER. Benefits are subject to a Lifetime Maximum of 1 operative procedure for morbid obesity per Consumer.

   No benefits are available for the repair or modification of any or all types of surgical morbid obesity procedures, except a Lifetime Maximum of 1 revision will be allowed per Consumer due to technical staple line failure. Benefits for all proposed surgical procedures for the treatment of complications resulting from any or all types of surgical morbid obesity procedures are available only when Prior Approval is received from INSURER.

## 2.3 TRANSPLANT SERVICES

A. Subject to the exclusions of this Benefit Plan, benefits are available for the following transplant procedures based on medical criteria if the recipient is a Consumer under this Benefit Plan. Benefits are not available under this Benefit Plan if the Consumer is the donor for transplant services. Covered Services must be received from a transplant facility approved by INSURER. Prior Approval is required.

   1. Heart
   2. Heart-lung
   3. Lung (single or double)
   4. Liver
   5. Pancreas
   6. Small bowel
   7. Kidney - Prior Approval is not required. Preauthorization may be required, see Section 3.2.
   8. Cornea - Prior Approval is not required. Preauthorization may be required, see Section 3.2.
   9. Bone marrow/stem cell transplants with related services and s supplies are covered subject to medical policy or medical guidelines.

B. Covered Services include:

   1. One evaluation is allowed per transplant procedure. Services must be performed at a qualified transplant center.

   2. Inpatient and outpatient Hospital and Medical Services for the recipient and the donor, if the living donor is not eligible for any other medical coverage.

   3. Surgical Services Including the evaluation and removal of the donor organ as well as transplantation of the organ or tissue into the recipient. Separate payment will not be made for the removal of an organ for transplantation at a later date.

   4. Compatibility testing services provided to the donor.

   5. Supportive medical procedures and clinical management services, Including postoperative procedures to control rejection and infection.

C. Benefits are not available for artificial organs, donor search services or organ procurement if the organ or tissue is not donated.

## 2.4 TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT TREATMENT

Temporomandibular (TMJ) or craniomandibular (CMJ) joint treatment, Including surgical and nonsurgical services, when such care and treatment is Medically Appropriate and Necessary as determined by INSURER. Benefits are subject to the Lifetime Maximum and the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

## 2.5 OUTPATIENT HOSPITAL AND MEDICAL SERVICES

Outpatient Hospital and Medical Services include:

A. Home and Office Visits and consultations for the examination, diagnosis and treatment of an illness or injury, Including administered Prescription Medications or Drugs.

B. Diagnostic Services when ordered by a Professional Health Care Provider.

C. Emergency Services.

D. Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth, or face. Covered Services must be initiated within 6 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by INSURER is in place. An accidental injury is defined as an injury that is the result of an external force causing a specific impairment to the jaw, sound natural teeth, dentures, mouth, or face. Injury as a result of chewing or biting is not considered an accidental injury.

E. Diagnosis and Treatment of Periodontal disease when recommended by a board-certified medical practitioner based on health-related impacts or further deterioration in existing acute or chronic disease state due to gum disease, including but not limited to periodontal scaling and root planing.

F. Surgical preadmission testing for Medically Appropriate and Necessary preoperative tests and studies provided on an outpatient basis prior to a Consumer's scheduled Admission to the Hospital as an Inpatient for surgery.

   Benefits are available only under the following conditions:

   1. The tests or studies would have been provided on an inpatient basis for the same condition; and

   2. The tests or studies are not repeated upon the Consumer's Admission to the Hospital.

G. Second surgical opinion consultations on covered elective surgery recommended by a Health Care Provider and those directly related Diagnostic Services required for a valid second surgical opinion. A second surgical opinion must be provided by a Professional Health Care Provider qualified to perform the suggested surgery and whose practice is unrelated to the Consumer's original Health Care Provider.

H. Radiation and Chemotherapy Services, except as limited by this Benefit Plan.

I. Dialysis Treatment.

J. Home Infusion Therapy services. Covered Services include the provision of nutrients, antibiotics, and other drugs and fluids intravenously, through a feeding tube, or by inhalation; all Medically Appropriate and Necessary supplies; and therapeutic drugs or other substances. Covered Services also include Medically Appropriate and Necessary enteral feedings when such feedings are the sole source of nutrition for a Consumer.

K. Allergy Services, Including serum, direct skin testing and patch testing when ordered by a Professional Health Care Provider and performed in accordance with medical guidelines and criteria established by INSURER. Guidelines and criteria for Medically Appropriate and Necessary services are available from a Participating Health Care Provider or INSURER.

L. Phenylketonuria. Testing, diagnosis, and treatment of Phenylketonuria, including dietary management and formulas.

M. Amino acid-based elemental oral formulas. Coverage for medical foods and low protein modified food products determined by a Physician to be Medically Appropriate and Necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

N. Dental anesthesia and hospitalization for dental care to Consumers under age 9, Consumers who are severely disabled or Consumers who have a medical condition that requires hospitalization or general anesthesia. Prior Approval is required for all Consumers age 9 and older.

## 2.6 WELLNESS SERVICES

A. Well child care for Consumers to their 6th birthday according to the guidelines supported by the Health Resources and Services Administration and in accordance with the schedule listed in the Schedule of Benefits, Section 1.

B. Immunizations that have been published as policy by the Centers for Disease Control as listed in the Schedule of Benefits, Section 1.

C. Preventive screening services for Consumers age 6 and older according to A or B Recommendations of the U.S. Preventive Services Task Force and issued by the Health Resources and Services Administration, Including those services listed in the Schedule of Benefits, Section 1. A Health Care Provider will counsel Consumers as to how often preventive services are needed based on the age, gender and medical status of the Consumer.

D. Outpatient nutritional care services provided by a Licensed Registered Dietitian when ordered by a Professional Health Care Provider. Covered Services include assessment of food practices and dietary/nutritional status and diet counseling for preventive and therapeutic needs for the diagnosed medical conditions listed in the Schedule of Benefits, Section 1. Coverage shall also be provided for the use of GLP1 and GIP drugs (specifically semaglutide and tirzepatide) as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity.

E. Diabetes care services include Outpatient Home and Office Visits, Diagnostic Services, Outpatient Nutritional Care Services, Diabetes Education Services, Dilated Eye Examinations, custom diabetic shoes and inserts and Outpatient Prescription Medications or Drugs and Diabetes Supplies. Benefits are subject to the Maximum Benefit Allowances as listed in the Schedule of Benefits, Section 1.

F. Tobacco cessation services subject to the guidelines listed in the Schedule of Benefits, Section 1. Benefits include the related Office Visit.

## 2.7 OUTPATIENT THERAPY SERVICES

A. Rehabilitative Therapy

Rehabilitative Services: therapies that are designed to restore function following a surgery or medical procedure, injury, or illness.

1. Physical Therapy: Benefits are available as listed in the Schedule of Benefits, Section 1, when performed by or under the direct supervision of a licensed Physical Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider. Benefits are not available for Maintenance Care.

2. Occupational Therapy: Benefits are available as listed in the Schedule of Benefits, Section 1, when performed by or under the direct supervision of a licensed Occupational Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider. Benefits are not available for Maintenance Care.

3. Speech Therapy: Benefits are available as listed in the Schedule of Benefits, Section 1, when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider. Benefits are not available for Maintenance Care.

B. Habilitative Therapy

Habilitative Physical Therapy, Occupational Therapy or Speech Therapy is care provided for conditions which have limited the normal age-appropriate motor, sensory or communication development. To be considered habilitative, functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Consumer's maximum potential.

Functional skills are defined as essential activities of daily life common to all Consumers such as dressing, feeding, swallowing, mobility, transfers, fine motor skills, age-appropriate activities, and communication. Problems such as hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance, an orthopedic impairment, autism spectrum disorders, traumatic brain injury, deaf-blindness, or multiple disabilities may warrant Habilitative Therapies.

Measurable progress emphasizes accomplishment of functional skills and independence in the context of the Consumer's potential ability as specified within a care plan or treatment goals.

C. Other Therapy Services

1. Respiratory Therapy services performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of patients with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.

2. Cardiac rehabilitation services subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

3. Pulmonary rehabilitation services subject to the Lifetime Maximum listed in the Schedule of Benefits, Section 1.

4. Vision Therapy: Including orthoptics and pleoptic training. Benefits are subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

## 2.8 CHIROPRACTIC SERVICES

Chiropractic services provided on an inpatient or outpatient basis when Medically Appropriate and Necessary as determined by INSURER and within the scope of licensure and practice of a Chiropractor, to the extent services would be covered if provided by a Physician. Benefits are subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Benefits are not available for maintenance care.

## 2.9 MATERNITY SERVICES

Benefits are available for Covered Services for pregnancy and complications of pregnancy. Benefits are limited to 2 ultrasounds per pregnancy unless, based on the Consumer's condition and history, additional services are determined to be Medically Appropriate and Necessary.

Benefits for inpatient maternity services allow a minimum stay of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. The Health Care Provider, after consulting with the mother, may discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Benefits for Outpatient Nutrition Care Services for Gestational Diabetes are available. See Outpatient Nutrition Care Services in the Schedule of Benefits, Section 1.

Benefits for lactation counseling are available.

If the newborn child is a Consumer, benefits are available from the moment of birth for routine nursery care and the treatment of any illness, accident, deformity, or congenital condition.

**Prenatal Plus Program**

The prenatal plus program is designed to identify women at higher risk for premature birth and to prevent the incidence of preterm birth through assessment, intervention, and education. Participation in the prenatal plus program is voluntary.

To participate, the Consumer must notify a Consumer Services representative after the first prenatal visit; preferably before the 12th week. The number to call regarding prenatal plus is on the back of the Identification Card. A Consumer Services representative will obtain the Consumer's name, Benefit Plan Number and t telephone number and request a medical management representative contact the Consumer.

A medical management representative will review the preterm labor risk assessment questionnaire with the Consumer. The questionnaire will take approximately ten minutes to complete. The information needed to complete this form is the Consumer's Benefit Plan Number, Professional Health Care Provider's name, address and telephone number and the Consumer's expected due date.

As a program participant, the Consumer will receive a packet containing information concerning pregnancy and prenatal care.

## 2.10 CONTRACEPTIVE SERVICES

Contraceptive services include Prescription Medications or Drugs and Payable Over the Counter (OTC) Drugs, birth control devices prescribed and dispensed by a Health Care Provider and related Office Visits provided by a Health Care Provider. Benefits Include:

A. Injections for birth control purposes.
B. Diaphragm or cervical cap.
C. Surgical implantation and removal of a contraceptive device.
D. Insertion and removal of an Intrauterine Device (IUD) - placement and removal is covered once every 5 years.
E. Outpatient surgical sterilization and related services. See Inpatient and Outpatient Surgical Services.
F. Contraceptive Prescription Medications and Drugs and Payable Over the Counter (OTC) Drugs, Including birth control pills, patches, and vaginal rings. See the Outpatient Prescription Medications or Drugs benefit.

In administering this Benefit Plan, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

## 2.11 PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

Guidelines and criteria for Medically Appropriate and Necessary services are available from INSURER.

A. Psychiatric Services

1. Inpatient

   Benefits are available for the inpatient treatment of psychiatric illness, including management of medical problems related to an eating disorder diagnosis, when provided by an appropriately licensed and credentialed Hospital or Psychiatric Care Facility. Preauthorization is required.

2. Residential Treatment For Consumers Under Age 21

   Benefits are available for the Residential Treatment of psychiatric illness for Consumers underage 21 when provided at an appropriately licensed and credentialed residential treatment center. Preauthorization is required.

3. Partial Hospitalization

   Benefits are available for the Partial Hospitalization of psychiatric illness when provided at an appropriately licensed and credentialed facility. Preauthorization is required.

4. Outpatient

   Benefits include diagnostic, evaluation and treatment services when provided by a Physician, Licensed Clinical Psychologist, Licensed Independent Clinical Social Worker, Licensed Professional Clinical Counselor and Advanced Practice Registered Nurse.

B. Substance Abuse Services

1. Inpatient

   Benefits are available for the inpatient treatment of substance abuse, including medically managed inpatient detoxification, medically monitored inpatient detoxification, medically managed intensive inpatient treatment, or medically monitored intensive inpatient treatment, when provided at an appropriately licensed and credentialed Substance Abuse Facility. Preauthorization is required.

   No benefits are available for non-inpatient pharmacological detoxification management, Including Outpatient, Intensive Outpatient Program (IOP), Partial Hospitalization program (PHP) setting, or Residential Treatment detoxification.

2. Residential Treatment For Consumers Under Age 21

   Benefits are available for the Residential Treatment of substance abuse for Consumers underage 21 when provided at an appropriately licensed and credentialed residential treatment center. Preauthorization is required.

3. Partial Hospitalization

   Benefits are available for the Partial Hospitalization of substance abuse when provided at an appropriately licensed and credentialed facility. Preauthorization is required.

4. Intensive Outpatient Program

   Benefits are available in an Intensive Outpatient Program for substance abuse, when provided by an appropriately licensed and credentialed Intensive Outpatient Program. Preauthorization is required.

5. Outpatient

   Benefits include diagnostic, evaluation and treatment services provided by a Physician, Licensed Clinical Psychologist or Licensed Addiction Counselor, including for gambling addiction.

## 2.12 AMBULANCE SERVICES

Medically Appropriate and Necessary Ambulance Services to the nearest facility equipped to provide the required level of care, including transportation:

- from the home or site of an Emergency Medical Condition.
- between Hospitals.
- between a Hospital and Skilled Nursing Facility.

Benefits for air transportation are available only when ground transportation is not Medically Appropriate and Necessary as determined by INSURER.

## 2.13 SKILLED NURSING FACILITY SERVICES

The benefits available under this Benefit Plan for Inpatient Hospital and Medical Services are also available for Skilled Nursing Services and supplies customarily provided to an Inpatient of a Skilled Nursing Facility when the condition requires daily Skilled Nursing Services that are Medically Appropriate and Necessary and such services can only be provided in a Skilled Nursing Facility.

## 2.14 HOME HEALTH CARE SERVICES

Home Health Care when provided to an essentially homebound Consumer in the Consumer's place of residence. The services must be provided on a part-time visiting basis according to a Professional Health Care Provider's prescribed plan of treatment approved by INSURER prior to Admission to Home Health Care.

Covered Services include:

1. The professional services of an R.N., Licensed Vocational Nurse or L.P.N.;
2. Physical, Occupational or Speech Therapy;
3. Medical and surgical supplies;
4. Administration of prescribed drugs;
5. Oxygen and the administration of oxygen; and
6. Health aide services for a Consumer who is receiving covered Skilled Nursing Services or Therapy Services.

B. No Home Health Care benefits will be provided for:

1. Dietitian services;
2. Homemaker services;
3. Social worker services;
4. Maintenance Care;
5. Custodial Care;
6. Food or home delivered meals; or
7. Respite care.

## 2.15 HOSPICE SERVICES

The benefits available under this Benefit Plan for Inpatient Hospital and Medical Services, Outpatient Hospital and Medical Services, Therapy Services, Skilled Nursing Facility Services and Home Health Care Services are also available when coordinated or provided through an organized and approved hospice program. Hospice benefits are provided only for the treatment of Consumers diagnosed with a condition where there is a life expectancy of 6 months or less.

## 2.16 MEDICAL SUPPLIES AND EQUIPMENT

Benefits are available for Medically Appropriate and Necessary medical supplies and equipment.

A. Home Medical Equipment

The rental or purchase, at the option of INSURER of new, used, or refurbished Home Medical Equipment, Including wheelchairs, hospital-type beds, infusion pumps and related supplies, crutches and canes when prescribed by a Professional Health Care Provider and Medically Appropriate and Necessary. Covered Services include replacement and repairs when Medically Appropriate and Necessary.

Benefits will not be provided for any Home Medical Equipment required for leisure or recreational activity or to allow a Consumer to participate in a sport activity.

B. Prosthetic Appliances and Limbs

The purchase, fitting and necessary adjustments of Prosthetic Appliances or Limbs and supplies that replace all or part of an absent body part. Benefits are available for standard Prosthetic Appliances and Limbs. Covered Services include repairs when Medically Appropriate and Necessary.

Benefits are available for externally worn breast prostheses and surgical bras, including necessary replacements following mastectomy, subject to a Maximum Benefit Allowance of 2 external prostheses and 2 bras per Consumer per Benefit Period. For a double mastectomy, allow a Maximum Benefit Allowance of 4 external prostheses and 2 bras per Consumer per Benefit Period.

Benefits are not available for dental appliances, artificial organs or Prosthetic Appliances and Limbs intended only for cosmetic purposes.

C. Orthotic Devices

Medically Appropriate and Necessary Orthotic Devices when ordered by a Professional Health Care Provider.

Benefits will not be provided for any Orthotic Devices available over the counter or those required for leisure or recreational activity or to allow a Consumer to participate in a sport activity. Benefits are not available for custom molded foot orthotics, except those used in custom diabetic shoes.

D. Supplies for Administration of Prescription Medications or Drugs

Therapeutic devices or appliances related to the administration of Prescription Medications or Drugs in the home, such as hypodermic needles and syringes. See Outpatient Prescription Medications or Drugs for diabetes supplies.

E. Oxygen

Administration of oxygen, Including the rental of equipment.

F. Ostomy Supplies

## 2.17 BREAST PUMPS

Benefits are available for the rental or purchase of a breast pump when provided by a participating Home Medical Equipment Supplier. The rental cost shall not exceed the Allowance of such equipment. No benefits are available for nursing-related supplies, Including bottles, breast milk storage bags and supplies related to bottles. Covered Services include replacement and repairs when Medically Appropriate and Necessary.

## 2.18 PEDIATRIC DENTAL SERVICES FOR CONSUMERS UNDER AGE 19

Covered Services are identified in accordance with categorizations established by The American Dental Association.

A Treatment Plan is recommended for services exceeding $1,500. All Orthodontic Services require a Treatment Plan. Prior Approval is required.

Benefits are subject to the Lifetime Maximum and the Maximum Benefit Allowances listed in the Schedule of Benefits, Section 1.

If, during the course of treatment, a Consumer transfers from the care of one Dentist to another, or if more than one Dentist provides services for the same dental procedure, INSURER will only be liable for the amount it would have paid if only one Dentist had provided the service.

If there are alternative courses of treatment, INSURER will provide benefits for the most cost-effective treatment.

## 2.19 PEDIATRIC VISION SERVICES FOR CONSUMERS UNDER AGE 19

A. Vision Examination

Benefits are available for routine vision examinations, Including refraction and glaucoma screening (tonometry test)

B. Prescribed Lenses and Frames

Benefits are available for prescribed single vision, bifocal or trifocal lenses and standard frames; Including directly related professional services

If other types of lenses and frames are received, reimbursement will be allowed up to the cost of a standard cost of lenses and frames. The Consumer will be responsible for charges over the lens and frame allowances. The tinting of lenses and ultraviolet lenses for eyeglasses or contact lenses is not covered.

No additional allowance is provided for non-line bifocal lenses.

Benefits are available for contact lenses in lieu of the prescribed frames and/or lenses benefit.

C. Post-Operative Refractive Examination(s)

Benefits are available for a post-operative refractive examination(s) when used instead of the benefits listed above.

## 2.20 EYEGLASSES OR CONTACT LENSES FOR CONSUMERS DIAGNOSED WITH APHAKIA

Benefits are available for 1 pair of prescribed lenses (bifocal or trifocal) and standard frames or contact lenses for Consumers diagnosed with aphakia (the absence of the lens of the eye, due to surgical removal, a perforated wound or ulcer, or a congenital condition resulting in complications that include the detachment of the vitreous or retina, and glaucoma).

## 2.21 OUTPATIENT PRESCRIPTION MEDICATIONS OR DRUGS

Benefits are available for Prescription Medications or Drugs approved by INSURER and that are Medically Appropriate and Necessary for the treatment of a Consumer and dispensed on or after the effective date of coverage. Benefits include the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions.

INSURER utilizes a formulary listing. This listing contains both Brand Name and Generic Prescription Medications or Drugs.

## SECTION 3
## MANAGED BENEFITS

### 3.1 PRIOR APPROVAL PROCESS

This Benefit Plan may require Consumers to obtain Prior Approval before benefits are available for specified services, Including:

A. chronic pain management programs;
B. cosmetic surgeries;
C. dental anesthesia and hospitalization for all Consumers age 9 and older;
D. electric wheelchairs;
E. growth hormone therapy/treatment;
F. human organ and tissue transplants, except kidney and corneal transplants;
G. insulin infusion pump;
H. morbid obesity surgery;
I. obstructive sleep apnea treatment, except for Continuous Positive Airway Pressure (CPAP);
J. Orthodontic services for Consumers under age 19;
K. Prosthetic Limbs and any Prosthetic Limb replacement;
L. Restricted Use Drugs; and
M. sleep studies performed at a facility not accredited by the American Academy of Sleep Medicine.

### 3.2 PREAUTHORIZATION

Preauthorization to INSURER may be required by each Consumer or the Consumer's representative prior to services being provided for the following services:

- Inpatient Admissions to a Health Care Provider not participating with INSURER;
- Skilled Nursing Facility;
- Long Term Acute Care Facility;
- Transitional Care Unit;
- Inpatient Admission to a Rehabilitation Facility;
- Hospice;
- Home Health Care;
- Psychiatric and Substance Abuse Admissions, including Inpatient, Partial Hospitalization or Residential Treatment; and
- Substance Abuse Intensive Outpatient Program.

Admissions for maternity services do not require Preauthorization.

## SECTION 4
## EXCLUSIONS

Benefits may not be available for the services listed in this section.

**EXCLUSIONS**

1. Services not prescribed or performed by or under the direct supervision of a Professional Health Care Provider consistent with the Professional Health Care Provider's licensure and scope of practice.

2. Services provided and billed by a registered nurse (other than an Advanced Practice Registered Nurse), intern (professionals in training), licensed athletic trainer or other paramedical personnel.

3. Inpatient Admission services received prior to the effective date of the Consumer's eligibility under this Benefit Plan.

4. Dental services provided to a Consumer prior to the effective date of the Consumer's eligibility. This includes dental services in progress before and concluded after the effective date of coverage, if received as part of an original Treatment Plan EXCEPT that coverage shall be provided for the diagnosis and treatment of periodontal disease when recommended by a board-certified medical practitioner based on health-related impacts or further deterioration in existing acute or chronic disease state due to gum disease.

5. Vision services provided to a Consumer prior to the effective date of the Consumer's eligibility under this Benefit Plan. This includes services in process before and concluded after the effective date of coverage.

6. Special education, counseling, therapy or care for learning disorders or mental retardation.

7. Education programs or tutoring services (not specifically defined elsewhere), Including education on self-care or home management.

8. Developmental delay care, Including services or supplies, regardless of where or by whom they are provided, that:

   - Are less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test; or

   - Are educational in nature; vocational and job rehabilitation, recreational therapy; or

   Special education, Including lessons in sign language to instruct a Consumer whose ability to speak has been lost or impaired to function without that ability, is not covered.

9. Counseling or therapy services, Including bereavement, codependency, marital, family, sex or interpersonal relationships.

10. Early Intensive Behavioral Intervention (EIBI) in all its forms, Including Applied Behavioral Analysis (ABA), Intensive Early Interventional Behavioral Therapy (IEIBT), Intensive Behavior Intervention (IBI), the Lovaas Method, Denver Model, LEAP, TEACCH, Pivotal Response Training and Discrete Trial Training.

11. Pharmacological detoxification management, except as specified in Section 2.11.

12. Clinically managed Residential Treatment detoxification, Including social detoxification.

13. Mental disability or mental disorder services that, according to generally accepted professional standards, are not amenable to favorable modification, except for initial evaluation, diagnosis or crisis intervention.

14. Any drug, device, medical service, treatment, or procedure that is Experimental or Investigative.

15. Services, treatments or supplies that the INSURER determines are not Medically Appropriate and Necessary.

16. Human organ and t issue transplants, except as specified in this Benefit Plan. Benefits are not available for transportation services for the Consumer. Benefits are not available for donor organs or tissue other than human donor organs or tissue.

17. Services that are related to annual, periodic, or routine examinations, except as specifically allowed in the Covered Services Section of this Benefit Plan.

18. Immunizations, testing, or other services required for foreign travel.

19. Inpatient services performed primarily for diagnostic examinations, Physical Therapy, rest cure, convalescent care, Custodial Care, Maintenance Care or sanitaria care.

20. Services by a vocational residential rehabilitation center, a community reentry program, Halfway House or Group Home.

    For the purpose of this exclusion, the following definitions apply:

    Halfway House - a facility for the housing or rehabilitation of persons on probation, parole, or early release from correctional institutions, or other persons found guilty of criminal offenses.

    Group Home - a facility for the housing or rehabilitation of developmentally, mentally or severely disabled persons that does not provide skilled or intermediate nursing care.

21. The surgical or nonsurgical treatment of temporomandibular (TMJ) or craniomandibular (CMJ) joint disorder(s), except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan. No benefits will be provided for Orthodontic services (except as determined Medically Appropriate and Necessary), or Osseo integrated implant surgery or related services performed for the treatment of temporomandibular or craniomandibular joint disorder(s).

22. Treatment leading to or in connection with sex change or transformation surgery and related complications.

23. Contraceptive products that do not require a Prescription Order or dispensing by a Health Care Provider.

24. Evaluations and related procedures to evaluate sterilization reversal procedures and the sterilization reversal procedure.

25. Abortions, except for those necessary to prevent the death of the woman. No benefits are available for removal of all or part of a multiple gestation.

26. Services related to infertility, Including Assisted Conception, donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of unfertilized sperm or eggs, Surrogate pregnancy and delivery, Gestational Carrier pregnancy and delivery, and preimplantation genetic diagnosis testing.

    For the purpose of this exclusion, the following definitions apply:

    Assisted Conception – a pregnancy resulting from insemination of an egg of a woman with sperm of a man by means other than sexual intercourse or by removal and implantation of a fertilized egg, gamete, zygote or embryo after sexual intercourse.

    Gestational Carrier - an adult woman who enters into an agreement to have a fertilized egg, gamete, zygote, or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.

    Surrogate - an adult woman who enters into an agreement to bear a child conceived through Assisted Conception for intended parents.

27. Genetic testing when performed in the absence of symptoms or high-risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of the Consumer's Physician.

28. Medications obtained without a Prescription Order or for any charges for the administration of legend drugs or insulin that may be s elf-administered unless such administration is Medically Appropriate and Necessary.

29. Prescription Medications or Drugs prescribed for sexual dysfunction.

30. Medical treatment and dietary management programs for obesity, except as specifically allowed in the Covered Services Section of this Benefit Plan. Benefits for surgical services performed for the treatment of morbid obesity are available only when Prior Approval is obtained from INSURER. Benefits are subject to a Lifetime Maximum of 1 operative procedure per Consumer. A Lifetime Maximum of 1 revision will be allowed per Consumer due to technical staple line failure. Benefits are not provided for repair or modification of a gastric bypass/banding procedure. Coverage shall also be provided for the use of GLP1 and GIP drugs (specifically semaglutide and tirzepatide) as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity.

31. Surgery and related services primarily intended to improve appearance and not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

32. Standby services provided or billed by a Health Care Provider.

33. Alternative treatment therapies, Including acupuncture, acupressure, aquatic whirlpool therapy, biofeedback, chelation therapy, massage therapy, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, music therapy or therapeutic touch.

34. Private duty nursing services.

35. Communication aids or devices to create, replace or augment communication abilities, Including hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication EXCEPT coverage shall be provided for one hearing aid per hearing-impaired ear every 36 months or more often if there is a significant change in the insured’s hearing status as determined by a licensed physician or audiologist. Hearing loss must be documents by a licensed physician or audiologist. Hearing aids must be purchased from a licensed audiologist.

36. All forms of thermography for all uses and indications.

37. Testicular prostheses regardless of the cause of the absence of the testicle.

38. Wigs, cranial prosthesis, or hair transplants.

39. Orthotic Devices available over the counter, Including orthopedic shoes and Home Medical Equipment required for leisure or recreational activities or to allow a Consumer to participate in sport activities unless Medically Appropriate and Necessary and approved by INSURER. Benefits are not available for custom molded foot orthotics, except for those used in custom diabetic shoes.

40. Palliative or cosmetic foot care, foot support devices (including custom made foot support devices) or subluxations of the foot, care of corns, bunions (except for capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. Benefits are available for the care of corns, calluses and toenails when Medically Appropriate and Necessary for Consumers with circulatory disorders of the legs or feet.

41. Dentistry or dental processes and related charges, Including extraction of teeth, dental appliances Including orthodontia placed in relation to a c overed oral surgical procedure, replacement of prosthetic appliances, replacement and/or repair of Orthodontic appliances, removal of impacted teeth, root canal therapy or procedures relating to the structures supporting the teeth, gingival tissues or alveolar processes, except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan.

42. Caries susceptibility tests.

43. Nutritional counseling for the control of dental disease, oral hygiene instruction and personal hygiene and convenience items.

44. Sealants on Deciduous teeth.

45. Surgical procedures for isolation of a tooth with a rubber dam.

46. Cosmetic bleaching of discolored teeth.

47. Ridge augmentation.

48. Application of desensitizing Medicaments.

49. Occlusal adjustment (limited/complete).

50. Enamel micro abrasion.

51. Application of desensitizing Medicaments.

52. Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue.

53. Appliances or restorations necessary to increase vertical dimensions or to restore an occlusion.

54. Maxillofacial prosthetics.

55. Dental implants.

56. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan. No benefits are available for routine vision examinations for Consumers age 1 9 and older. No benefits are available for refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses or complications resulting from refractive surgery. No benefits are available for eyeglasses or contact lenses following cataract surgery.

57. The replacement of lost or broken lenses or frames unless at the time of replacement the Consumer is eligible for prescribed lenses or frames.

58. Costs incurred above the Allowance for cosmetic attachments to lenses or frames such as:

    a. monograms or facets;
    b. roll or polish edges for rimless lenses;
    c. tinting of lenses; i.e., photo gray for glass lenses and transition for plastic lenses;
    d. slimlite or hi-index lenses;
    e. polythin or polycarbonate lenses;
    f. oversized lenses; i.e., large, or oversize goggle blanks;
    g. highpower;
    h. specialty lenses; i.e., Smart Seq., executive, bifocal or trifocal extra wide.

59. Visual field exams.

60. Sunglasses.

61. Safety lenses.

62. Protective or scratch coating for plastic lenses.

63. Slab-off lenses.

64. Contact lens cleaning supplies and contact lens fitting fee.

65. Hearing aids or examinations for the prescription or fitting of hearing aids EXCEPT coverage shall be provided for one hearing aid per hearing-impaired ear every 36 months or more often if there is a significant change in the insured's hearing status as determined by a licensed physician or audiologist. Hearing loss must be documents by a licensed physician or audiologist. Hearing aids must be purchased from a licensed audiologist. No benefits are available for routine hearing examinations. No benefits are available for a tinnitus masker.

66. Services when benefits are provided by any governmental unit or social agency, except for Medicaid or when payment has been made under Medicare Part A or Part B. Medicare Part A and Part B will be considered the primary payor with respect to benefit payments unless otherwise required by federal law.

67. Illness or injury caused directly or indirectly by war or an act of war or sustained while performing military services, if benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof.

68. Illness or bodily injury that arises out of and in the course of a Consumer's employment if benefits or compensation for such illness or injury are available under the provisions of a state workers' compensation act, the laws of the United States or any state or political subdivision thereof.

69. Loss caused or contributed by a Consumer's commission or attempted commission of a felony (except losses caused or contributed by an act of domestic violence or any health condition) or a Consumer's involvement in an illegal occupation following the Consumer's enrollment in this Benefit Plan.

70. Any services when benefits are provided by a medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, similar person, or group.

71. Services provided by a Health Care Provider who is a member of the Consumer's Immediate Family.

72. The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.

The following methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Auto injections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy.

This exclusion also includes clinical ecology, orthomolecular therapy, vitamins or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.

73. Telephone consultations or charges for failure to keep a scheduled visit or charges for completion of any forms required by INSURER.

74. Personal hygiene and convenience items, Including air conditioners, humidifiers or physical fitness equipment.

75. Health screening assessment programs or health education services, Including all forms of communication media whether audio, visual or written.

76. Health and athletic club consumership or facility use, and all services provided by the facility, Including Physical Therapy, sports medicine therapy and physical exercise.

77. Artificial organs, donor search services or organ procurement if the organ or tissue is not donated.

78. Prosthetic Limbs or components intended only for cosmetic purposes or customized coverings for terminal devices. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a Consumer to participate in sport activities.

79. Physical Therapy Maintenance Care, Occupational Therapy Maintenance Care or Speech Therapy Maintenance Care, work hardening programs, prevocational evaluation, functional capacity evaluations or group speech therapy services.

80. Chiropractic maintenance care that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent further problems.

81. Complications resulting from noncovered services received by the Consumer.

82. Services prescribed by, performed by or under the direct supervision of a Nonpayable Health Care Provider.

83. Services that a Consumer has no l egal obligation to pay in the absence of this or any similar coverage.

84. Cost Sharing Amounts.

85. Services when Prior Approval was required but not obtained.

86. Brand Name prescription tobacco deterrents if Generic equivalent is available.

87. Low protein modified food products or medical food for amino acid-based disease or phenylketonuria (PKU), to the extent those benefits are available under a department of health program or other state agency.

88. Food items for medical nutrition therapy, except as specifically allowed in the Covered Services Section of this Benefit Plan.

89. Collection and storage of umbilical cord blood.

90. Services, treatments or supplies not specified as a Covered Service under this Benefit Plan.

## SECTION 8
## DEFINITIONS

This section defines the terms used in this Benefit Plan. These terms will be capitalized throughout this Benefit Plan when referred to in the context defined. INSURER shall determine the interpretation and application of the Definitions in each and every situation.

**AMBULATORY (OUTPATIENT) SURGERY** - surgery performed in the outpatient department of a Hospital, Ambulatory Surgical Facility or Professional Health Care Provider's office.

**ANCILLARY SERVICES** - services required for the treatment of a Consumer in a Hospital, other than room, board and professional services.

**BITEWING** - dental X-rays showing the area around the teeth.

**BRUXISM** - the grinding of the teeth.

**COST SHARING AMOUNTS** - the dollar amount a Consumer is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided. See Section 1, Schedule of Benefits for the specific Cost Sharing Amounts that apply.

A. **Coinsurance Amount** - a percentage of the Allowed Charge for Covered Services that is the consumer's responsibility.

B. **Copayment Amount** - a specified dollar amount payable by the Consumer for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service.

C. **Deductible Amount** - a specified dollar amount payable by the Consumer for certain Covered Services.

D. **Out-of-Pocket Maximum Amount** - the total Deductible, Coinsurance and Copayment Amounts for certain Covered Services that are a Consumer's responsibility.

**COVERED SERVICE** - Medically Appropriate and Necessary services and supplies for which benefits are available when provided by a Health Care Provider.

**CROWN** - the restoration covering or replacing the major part of a tooth.

**CUSTODIAL CARE** - care that INSURER determines is designed essentially to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.

**DECIDUOUS** - the primary teeth.

**DENTURE** - an artificial substitute for natural teeth and adjacent tissues.

E. **Immediate Denture** - the prosthesis constructed for placement immediately after the removal of remaining natural teeth.

F. **Rebase of Denture** - the process of refitting a Denture by replacing the base material.

G. **Reline of Denture** - the process of resurfacing the tissue side of a Denture with new base material.

**DIAGNOSTIC SERVICE** - a test or procedure provided because of specific symptoms and directed toward the determination of a definite condition. A Diagnostic Service must be ordered by a Professional Health Care Provider. Diagnostic Services include but are not limited to X-ray and other imaging services, laboratory and pathology services, cardiographic, encephalographic and radioisotope tests.

**EMERGENCY MEDICAL CONDITION** - a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

**EMERGENCY SERVICES** - health care services, supplies or treatments furnished or required to screen, evaluate and treat an Emergency Medical Condition.

**ENDODONTICS** - the treatment of disease and injuries of the inner tooth (pulp) and surrounding area.

**FILLING** - a term used for the restoration of lost tooth structure by using materials such as metal, alloy, plastic or cement.

H. **Amalgam** - the alloy used in direct dental restorations.

I. **Composite** - a dental restorative material made up of disparate or separate parts.

**FLUORIDE** - a solution that is topically applied to the teeth for the purpose of preventing dental decay.

**GINGIVAL CURETTAGE** - a scraping or cleaning of the walls of a cavity or gingival pocket.

**HOME HEALTH CARE** - Skilled Nursing Services provided under active Physician and nursing management through a central administrative unit coordinated by a registered nurse.

**HOME HEALTH VISIT** - the provision of skilled nursing and other therapeutic services to a Consumer confined to their home.

**HOME MEDICAL EQUIPMENT** - items that can withstand repeated use and are primarily used to serve a medical purpose outside of a heal th care facility. Such items would not be of use to a person in the absence of illness, injury, or disease.

**INCLUDING** - means including, but not limited to.

**INPATIENT** - a person confined as a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.

**MAINTENANCE CARE** - treatment provided to a Consumer whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. Exception: periodic reassessments are not considered Maintenance Care.

**MALOCCLUSION** - the improper alignment of biting and chewing surfaces of upper and lower teeth.

**MEDICAMENTS** - Includes oral antibiotics, oral sedatives and topical fluorides dispensed in the Dentist's office for home use. Prescription Medications or Drugs are not considered Medicaments.

**OFFICE VISIT** - a professional service, Including an examination for the purpose of diagnosing or treating an illness or injury or the determination, initiation or monitoring of a treatment plan provided in an outpatient setting by a Professional Health Care Provider.

**ORAL AND MAXILLOFACIAL SURGERY** - the dental surgical services that are limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects, and aesthetic aspects of the oral and maxillofacial area.

**ORTHODONTIC** - the interception and treatment of Malocclusion of the teeth and their surrounding structures.

**ORTHOTIC DEVICES** - any rigid or semi-rigid supportive device that restricts or eliminates the motion of a weak or diseased body part.

**OUTPATIENT** - a person treated as a registered Outpatient at a Hospital, clinic or in a Professional Health Care Provider's office, who is not, at the time of treatment, a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.

**PARTIAL HOSPITALIZATION** - continuous structured multidisciplinary treatment of mental illness or substance abuse by a Health Care Provider, usually held during the daytime hours and generally providing 20 or more hours per week to treat multidimensional instability not requiring 24-hour care. Preauthorization is required.

**PERIODONTIC** - the practice limited to the treatment of diseases of the supporting or surrounding tissues of the teeth.

**PERMANENT TEETH** - the natural teeth that replace the deciduous or primary teeth.

**PRESCRIPTION MEDICATION OR DRUG** - any legend drug, Payable Over the Counter (OTC) Drug, biologic or insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for the treatment of the disease or illness for which the Consumer is receiving care.

J. **Brand Name** - the registered trademark name of a Prescription Medication or Drug by its manufacturer, labeler or distributor.

K. **Formulary Drug** - a Brand Name or Generic Prescription Medication, Drug, or diabetes supply that is a safe, therapeutically effective, high quality and cost-effective drug as determined by a committee of Physicians and Pharmacists.

L. **Generic** - the established name or official chemical name of the drug, drug product or medicine.

M. **Nonformulary Drug** - a Prescription Medication, Drug, or diabetes supply that is not a Formulary Drug.

N. **Nonpayable Drug** - a Prescription Medication or Drug that is not reimbursed by INSURER or is included in Section 4, Exclusions.

O. **Payable Over the Counter (OTC) Drug** - a medication or drug approved by the U.S. Food and Drug Administration for marketing without a Prescription Order and approved by INSURER when dispensed by a Pharmacist upon the receipt of a Prescription Order.

P. **Restricted Use Drug** - a Prescription Medication or Drug that may require Prior Approval and/or be subject to a limited dispensing amount.

Q. **Specialty Drug** - an Outpatient Prescription Medication or Drug listed on the Specialty Drug list.

**PRESCRIPTION ORDER** - the order for a Prescription Medication or Drug issued by a Professional Health Care Provider licensed to make such order in the ordinary course of professional practice.

**PROPHYLAXIS** - the scaling and polishing procedure performed to remove coronal plaque, calculus, and stains.

**PROSTHETIC APPLIANCE OR LIMB** - a fixed or removable artificial body part that replaces an absent natural part.

**RESIDENTIAL TREATMENT** - 24-hour care under the clinical supervision of a Health Care Provider, in a residential treatment center other than an acute care hospital, for the active treatment of chemically dependent or mentally ill persons and to stabilize multidimensional imminent risk. Preauthorization is required.

**SKILLED NURSING SERVICES** - services that can be safely and effectively performed only by or under

the direct supervision of licensed nursing personnel and under the direct supervision of a Professional Health Care Provider.

**SPECIAL CARE UNIT** - a section, ward or wing within a Hospital operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered nurses or other highly trained personnel, excluding any section, ward or wing within a Hospital maintained for the purpose of providing normal postoperative recovery treatment services.

**TREATMENT PLAN** - a written report prepared by the Dentist that recommends the treatment of a dental disease, defect, or injury for a Consumer.

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