Benefits for Healthcare Coverage

The South Dakota Benchmark Plan

The South 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.

The following document will serve as South Dakota's Essential Health Benefits (EHB) Benchmark plan as required in 45 CFR 156.100. Individual and small group market issuers in South Dakota may need to conform plan benefits to meet applicable federal and state EHB requirements when designing plans that are substantially equal to this EHB benchmark plan.

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.

Absent a selection by the state, the largest small-group plan has served as the benchmark plan from 2014-2020.

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 South Dakota Division of Insurance (DOI) is utilizing the greater flexibility granted by CMS in **Option 3** to update their EHB benchmark plans to help address the gaps in treatment of Autism Spectrum Disorder(s) for plan year 2021.

Under Option 3, the State is allowed to develop its benchmark plan by selecting a set of benefits rather than an existing plan offered in the market. Therefore, in the process of developing the 2021 EHB benchmark plan, the South Dakota DOI started with the 2020 EHB benchmark as the basis and added one new benefit.

As required per federal regulation, the South Dakota DOI submitted an actuarial report and certification that demonstrates the proposed 2021 EHB benchmark plan meets the following two actuarial requirements:

1. The EHB benchmark plan must be equal to, or greater than the scope of benefits provided under a typical employer plan; and

2. The EHB benchmark plan does not exceed the generosity of the most generous among the plans listed at Section 156.111(b)(2)(ii).

The first requirement states the EHB benchmark plan must be equal to or greater than the scope of benefits provided under a typical employer plan. The starting point for the proposed benchmark is the current 2020 benchmark, which is one of the most popular small group plans offered in South Dakota. Further, since it is the current 2020 benchmark plan, it already meets the criteria of being equal to or greater than a typical employer plan. The SDDOI has elected to add one benefit or criteria to the 2020 benchmark plan. Since the SDDOI is enhancing the plans, the proposed benchmark continues to meet the criteria of the first requirement.

The second requirement states the EHB benchmark plan does not exceed the generosity of the most generous among the plans listed at Section 156.111(b)(2)(ii). To demonstrate compliance with this requirement, we performed a cost study on each of the recommendations to determine the materiality of the new benefit or criteria and the impact it would have on the overall premiums of the benchmark plan. For more information, please see the detailed actuarial report from Leif Associates.

The Federal Employees Dental and Vision Insurance Program (FEDVIP) plans are the supplemental benchmark plans designated by the Center for Consumer Information and Insurance Oversight (CCIIO)/Centers for Medicare & Medicaid Services (CMS)for guidance in pediatric dental and vision benefit coverage. The current FEDVIP plans for dental and vision are the MetLife Federal Dental Plan (High Option) and FEP BlueVision (High Option). See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf.

South Dakota will use the same approach as outlined in 45 CFR §156.122(a)(1) and (2) for its drug benefit. Issuers may not have to cover the specific drugs listed on the benchmark drug list but are required to fill any empty/deficient categories and must meet the drug category/class count standard as established by CMS.

The State of South Dakota has not included any additional EHB benefits pursuant to 45 CFR 155.170. Nothing in this 2021 Benchmark plan should be construed as additional EHB requirements under Federal Law. At no time shall the set of benefits listed below be construed to allow an issuer to NOT cover any and all federal and state required benefits.

Contents

1. At a Glance - Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not.

Set of Benefits

Category	Covered	Not Covered	Service Maximum
Acupuncture Treatment		⊘	
Alcoholism Treatment	☒		30 days per six-month period for inpatient treatment. 90 days per lifetime for inpatient treatment.
Allergy Testing and Treatment	☒		
Ambulance Services	☒		
Anesthesia	☒		
Autism Spectrum Disorder	☒		
Blood Administration	☒		
Chemical Dependency Treatment	☒		30 days per benefit year for inpatient treatment.
Chemotherapy and Radiation Therapy	☒		
Contraceptives	☒		
Cosmetic Services		⊘	
Counseling and Education Services		⊘	
Dental Treatment for Accidental Injury	☒		
Dialysis	☒		
Education Services for Diabetes	☒		Two diabetic education programs per lifetime. Eight visits per benefit year for follow-up training.
Emergency Services	☒		
Fertility Services	☒		
Genetic Testing	☒		
Hearing Services (related to an illness or injury)	☒		
Home Health Services	☒		
Home/Durable Medical Equipment	☒		
Hospice Services	☒		15 days per lifetime for inpatient hospice respite care. 15 days per lifetime for outpatient hospice respite care. **Please note:** Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	☒		90 days per benefit year for skilled nursing services in a hospital or nursing facility.
Illness or Injury Services	☒		

Category	Covered	Not Covered	Service Maximum
Infertility Treatment		⊘	
Inhalation Therapy	☒		
Maternity Services	☒		
Medical and Surgical Supplies	☒		
Mental Health Services	☒		
Morbid Obesity Treatment	☒		
Motor Vehicles		⊘	
Musculoskeletal Treatment	☒		
Nonmedical Services		⊘	
Occupational Therapy	☒		
Orthotics		⊘	
Physical Therapy	☒		
Prescription Drugs	☒		
Preventive Care	☒		One routine physical examination per benefit year. One routine mammogram per benefit year. One routine gynecological examination per benefit year. One diagnostic screening for prostate cancer, including digital rectal examination and prostate-specific antigen (PSA) test, for: • Asymptomatic men aged 50 and older; • Men 45 and older who are at a high risk for prostate cancer.
Prosthetic Devices	☒		
Reconstructive Surgery	☒		
Self Help Programs		⊘	
Sleep Apnea Treatment	☒		
Speech Therapy	☒		
Surgery	☒		
Temporomandibular Joint Disorder (TMD)	☒		
Transplants	☒		
Travel or Lodging Costs		⊘	
Vision Services (related to an illness or injury)	☒		
Wigs or Hairpieces		⊘	
X-ray and Laboratory Services	☒		

Prescription Drug Plan

Prescription Drug Category	Covered	Not Covered	Prescription Maximum
Brand Name Prescription Drugs	☒		Retail Non-Maintenance Prescriptions a 30-day supply. Retail Maintenance Prescriptions a 90-day supply. Mail Order Non-Maintenance Prescriptions a 30-day supply Mail Order Maintenance Prescriptions a 90-day supply.
Chemical Dependency Drugs	☒		
Contraceptives	☒		
Convenience Packaging		⊘	
Cosmetic Drugs		⊘	
Drugs that are Lost, Damaged, Stolen, or Used Inappropriately		⊘	
Drugs You Abuse		⊘	
Generic Prescription Drugs	☒		Retail Non-Maintenance Prescriptions a 30-day supply. Retail Maintenance Prescriptions a 90-day supply. Mail Order Non-Maintenance Prescriptions a 30-day supply. Mail Order Maintenance Prescriptions a 90-day supply.
Immunization Agents	☒		
Impotence Drugs	☒		
Infertility Drugs		⊘	
Insulin and Diabetic Supplies	☒		
Irrigation Solutions and Supplies		⊘	
Nutritional and Dietary Supplements	☒		
Over-the-Counter Products		⊘	
Self-Administered Injectable Drugs	☒		
Self-Help Drugs		⊘	
Therapeutic Devices or Medical Appliances		⊘	
Weight Reduction Drugs		⊘	

2. Details - Covered and Not Covered

Set of Benefits

ACUPUNCTURE TREATMENT
Not Covered: Your set of benefits do not cover acupuncture and acupressure treatment.

ALCOHOLISM TREATMENT
Covered: Your benefits provide coverage for alcoholism treatment. However, for treatment in a residential treatment facility, benefits are available only if treatment is provided as an inpatient at an acute level of care with 24-hour registered nursing care under the supervision of a medical director.

Service Maximum:

- 30 days per six-month period for inpatient treatment.
- 90 days per lifetime for inpatient treatment.

Not Covered: Your benefits do not provide treatment received in a residential treatment facility, except the acute level of care described under Covered above.

ALLERGY TESTING AND TREATMENT
Covered: Your benefits provide coverage for allergy testing and treatment.

AMBULANCE SERVICES
Covered: Your benefits provide coverage for professional air and ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates. All of the following are required to qualify for benefits:

- No other method of transportation is appropriate.
- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.

ANESTHESIA
Covered: Your benefits include coverage for anesthesia and the administration of anesthesia.
Not Covered: Your benefits do not include coverage for local or topical anesthesia billed separately from related surgical or medical procedures.

AUTISM SPECTRUM DISORDER(S)
Covered: Your benefits include coverage for diagnosis and treatment of Autism Spectrum Disorder. Autism Spectrum Disorder is a complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive, stereotyped patterns of behavior. When medically necessary, Applied Behavior Analysis (ABA) services are covered for the treatment of Autism Spectrum Disorder for children age 18 and younger. ABA services must be performed or supervised by a South Dakota licensed physician or psychologist who has documented training and competence in ABA or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation of board-certified licensed behavior analyst.

Minimum Coverage Limit:

- ABA services for the treatment of Autism Spectrum Disorders for children age 18 and

younger:

- For children through age six: 1,300 hours per benefit year.
- For children age seven through 13: 900 hours per benefit year.
- For children age 14 through age 18: 450 hours per benefit year.

Not Covered: Your benefits do not provide coverage for the following:

- ABA services for the treatment of Autism Spectrum Disorder for children age 19 and older.
- ABA services other than for treatment of Autism Spectrum Disorder.

BLOOD ADMINISTRATION

Covered: Your benefits include coverage for blood administration.
Not Covered: Your benefits do not include coverage for blood. This exclusion does not apply to members with hemophilia.

CHEMICAL DEPENDENCY TREATMENT

Covered: Your benefits include coverage for treatment for a condition with physical or psychological symptoms produced by the habitual use of certain drugs as described in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised (DSM-IV-R)* or subsequent revisions. For treatment in a residential treatment facility, benefits are available only if treatment is provided as an inpatient at an acute level of care with 24-hour registered nursing care under the supervision of a medical director.

Service Maximum:

- 30 days per benefit year for inpatient treatment (excluding treatment of alcoholism).

Not Covered: Your benefits do not include treatment received in a residential treatment facility, except the acute level of care described under Covered.

CHEMOTHERAPY AND RADIATION THERAPY

Covered: Your benefits include coverage for the use of chemical agents or radiation to treat or control a serious illness.

CLINICAL TRIALS

In certain cases, you may be covered for routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
Covered: Your coverage includes benefits for medically necessary routine patient costs for items and services otherwise covered under this set of benefits furnished in connection with participation in an approved clinical trial related to the treatment of cancer or other life-threatening diseases or conditions, when referred by a provider based on the conclusion that you are eligible to participate in an approved clinical trial according to the trial protocol or you provide medical and scientific information establishing that your participation in the clinical trial would be appropriate according to the trial protocol.
Not Covered: Your set of benefits may not include:

- Investigational or experimental items, devices, or services which are themselves the subject of the clinical trial;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

CONTRACEPTIVES

Covered: Your benefits include coverage for the following conception prevention, as approved by the U.S. Food and Drug Administration:

- Contraceptive medical devices, such as intrauterine devices and diaphragms.
- Implanted contraceptives.
- Injected contraceptives.

Not Covered: Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches. These are covered under your prescription drug plan.

COSMETIC SERVICES

Not Covered: Your benefits do not include cosmetic services, supplies, or drugs if provided primarily to improve physical appearance. A service, supply, or drug that results in an incidental improvement in appearance may be covered if it is provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect. You are also not covered for treatment for any complications resulting from a noncovered cosmetic procedure.

COUNSELING AND EDUCATION SERVICES

Not Covered: Your benefits do not include:

- coverage for bereavement counseling or services (including volunteers or clergy), family counseling or training services, and marriage counseling or training services.
- coverage for education or educational therapy other than covered education for self-management of diabetes.

DENTAL SERVICES *(For Pediatric Dental Services benefit guidance see FEDVIP supplemental dental plan)*

Covered: Your benefits include coverage for:

- Dental treatment for accidental injury when:
  - Treatment is completed within 12 months of the injury.
- Dental treatment for children and disabled persons as follows:
  - Anesthesia and hospital charges for dental care, whether services are provided in a hospital or a dental office, when the covered individual:
    - is under age 14; or
    - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed physician which places such person at serious risk.
- Impacted teeth removal (surgical) as an inpatient or outpatient of a facility only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Orthodontic services required for surgical management of cleft palate.
- Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered: Your benefits do not include coverage for the following:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, cast restorations, dentures and bridges, and orthodontic services unrelated to surgical management of cleft palate.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease.

DIALYSIS

Covered: Your benefits provide coverage for the removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

EDUCATION SERVICES FOR DIABETES

Covered: Your benefits provide coverage for inpatient and outpatient training and education for the self-management of all types of diabetes mellitus.

All covered training or education must be prescribed by a licensed physician. Outpatient training or education must be provided by a qualified diabetes educator and recognized by the American Diabetes Association (ADA) or use a curriculum approved by the ADA or the South Dakota Department of Health.

A diabetes educator is a physician, nurse, dietitian, pharmacist, or other licensed health care provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetes Educators and has completed a course in diabetic education and training or has been certified as a diabetes educator.

Certified diabetic education programs help a person with any type of diabetes and his or her caretaker understand the diabetes disease process and the daily management of diabetes.

Service Maximum:

- Two certified diabetes education programs per member per lifetime; and
- Eight visits per benefit year for follow-up training once you have participated in a diabetes education program.

EMERGENCY SERVICES

Covered: Your benefits provide coverage for emergency services when treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

FERTILITY SERVICES

Covered: Your benefits provide coverage for fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).

GENETIC TESTING

Covered: Your benefits provide coverage for genetic molecular testing (specific gene identification) and related counseling when both of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.).
- The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

HEARING SERVICES

Covered: Your benefits provide coverage for hearing examinations, but only to test or treat hearing loss related to an illness or injury.

Not Covered: Your benefits do not provide coverage for hearing aids or routine hearing examinations.

HOME HEALTH SERVICES

Covered: Your benefits provide coverage for home health services when all of the following requirements are met:

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.

The following are covered home health services and supplies:

- Home Health Aide Services—when provided in conjunction with a medically necessary skilled service also received in the home.
- Home Skilled Nursing. Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency.
    - Home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting. Custodial care is NOT included in this benefit.
- Inhalation Therapy.
- Medical Equipment.
- Medical Social Services.
- Medical Supplies.
- Occupational Therapy—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are NOT covered for occupational therapy supplies.
- Oxygen and Equipment for its administration.
- Parenteral and Enteral Nutrition.
- Physical Therapy.
- Prescription Drugs and Medicines administered in the vein or muscle.
- Prosthetic Devices and Braces.
- Speech Therapy.

Not Covered: Your benefits do not include coverage for custodial home care services and supplies, which help you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. You are also NOT covered for sanitaria care or rest cures.

HOME/DURABLE MEDICAL EQUIPMENT

Covered: Your benefits provide coverage for equipment that meets all of the following requirements:

- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.

- Used to serve a medical purpose.

HOSPICE SERVICES

Covered: Your benefits provide coverage for care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. Hospice care covers the same services as described under Home Health Services, as well as hospice respite care from a facility approved by Medicare or by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). Hospice respite care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital.

Service Maximum:

- 15 days per lifetime for inpatient hospice respite care.
- 15 days per lifetime for outpatient hospice respite care.
- Not more than five days of hospice respite care at a time.

HOSPITAL AND FACILITIES

Covered: Your benefits provide coverage for hospitals and other facilities that meet standards of licensing, accreditation or certification. Following are some recognized facilities:

- Ambulatory Surgical Facility. This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed.
- Chemical Dependency Treatment Facility. This is a licensed freestanding facility approved to provide treatment of chemical dependency conditions (including alcoholism) in a residential or hospital setting or pursuant to a certified intensive outpatient treatment program.
- Community Mental Health Center. This type of facility provides outpatient treatment of mental health conditions and must be licensed and approved by us.
- Hospital. This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must be licensed as a hospital under applicable law.
- Nursing Facility. This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.
- Residential Treatment Facility. This is a licensed facility other than a hospital or nursing facility that provides residential treatment for severe, persistent or chronic mental health conditions or chemical dependency (including alcoholism) at an acute level of care with 24-hour registered nursing care under the supervision of a medical director.

Service Maximum:

- 90 days per benefit year for skilled nursing services in a hospital or nursing facility.

ILLNESS OR INJURY SERVICES

Covered: Your coverage provides benefits for services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this set of benefits. This includes pregnancy and complications of pregnancy.

Treatment may be received from an approved provider in any of the following settings:

- Home.
- Inpatient (such as a hospital or nursing facility).
- Office (such as a doctor's office).
- Outpatient.

INFERTILITY TREATMENT

Not Covered: Your benefits do not include coverage for the following:

- Infertility treatment if the infertility is the result of voluntary sterilization.
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing of sperm, oocytes, or embryos; surrogate parent services.
- Infertility diagnosis and treatment.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

INHALATION THERAPY

Covered: Your benefits include coverage for respiratory or breathing treatments to help restore or improve breathing function.

MATERNITY SERVICES

Covered: Your benefits include coverage for prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

In accordance with federal or applicable state law, maternity services include a minimum of:

- 48 hours of inpatient care (in addition to the day of delivery care) following a vaginal delivery; or
- 96 hours of inpatient care (in addition to the day of delivery) following a cesarean section.

The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable. If the inpatient hospital stay is shorter, coverage includes a follow-up postpartum home visit by a registered nurse (R.N.).

MEDICAL AND SURGICAL SUPPLIES

Covered: Your benefits include coverage for medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Diabetic equipment and supplies including insulin syringes.

Not Covered:

- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

MENTAL HEALTH SERVICES

Benefits will be provided for treatment of mental health conditions and chemical dependency.

Covered: Your benefits provide coverage for treatment for certain psychiatric, psychological, or emotional conditions as an inpatient or outpatient. Covered facilities for mental health services include licensed and accredited residential treatment facilities and community mental health centers.

Coverage includes diagnosis and treatment of these biologically based mental illnesses:

- Schizophrenia and other psychotic disorders.
- Bipolar disorders.
- Major depressive disorders.
- Schizo-affective disorders.
- Obsessive-compulsive disorders.

- Pervasive developmental disorders.

A mental health condition must satisfy the following criteria:

- The disorder is classified as a mental health condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised (DSM-IV-R)* or subsequent revisions.
- The disorder is listed only as a mental health condition in the most current *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* and not dually listed elsewhere in the ICD-10-CM.
- The disorder is not a chemical dependency condition (including alcoholism).
- The disorder is a behavioral or psychological condition not attributable to a mental disorder that is the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered covered under this medical set of benefits.

For treatment in a residential treatment facility, benefits are available only if treatment is provided as an inpatient at an acute level of care with 24-hour registered nursing care under the supervision of a medical director.

Not Covered: Your benefits do not include coverage for the following:

- Certain disorders related to early childhood, such as academic underachievement disorders.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Nonpervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual identification or gender disorders.
- Treatment received in a residential treatment facility, except the acute level of care described under Covered.

MORBID OBESITY TREATMENT

Covered: Your benefits include coverage for weight reduction surgery provided the surgery is medically necessary for your condition. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is required.

Not Covered: Your benefits do not include coverage for weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

MOTOR VEHICLES

Not Covered: Your benefits do not provide coverage for the purchase or rental of motor vehicles such as cars or vans. You are also not covered for equipment or costs associated with converting a motor vehicle to accommodate a disability.

MUSCULOSKELETAL TREATMENT

Covered: Your benefits include coverage for outpatient nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease.

Not Covered: Your benefits do not include coverage for massage therapy.

NONMEDICAL SERVICES

Not Covered: Your benefits do not include coverage for such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy, and any services or supplies that

are nonmedical.

OCCUPATIONAL THERAPY

Covered: Your benefits do include coverage for occupational therapy services, but only those services to treat the upper extremities, which means the arms from the shoulders to the fingers.
Not Covered: Your benefits do not include coverage for the following:

- Occupational therapy supplies.
- Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

ORTHOTICS

Not Covered: Your benefits do not include coverage for orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices.

PHYSICAL THERAPY

Covered. Your benefits include coverage for physical therapy services when all the following requirements are met:

- The goal of the physical therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation and habilitation is significant in relation to the extent and duration of services.
- The expectation for improvement is in a reasonable (and generally predictable) period of time.
- There is evidence of improvement by successive objective measurements whenever possible.

Not Covered: Your benefits do not include:

- Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Physical therapy performed for maintenance.
- Physical therapy services that do not meet the requirements specified under "Covered."

PRESCRIPTION DRUGS

Covered: Your benefits for most prescription drugs and medicines that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription" are generally covered under your prescription drug plan, not under this medical benefits plan. However, there are exceptions when prescription drugs and medicines are covered under this medical set of benefits.
Drugs classified by the FDA as Drug Efficacy Study Implementation (DESI) drugs may also be covered. For a list of these drugs, check with your pharmacist or physician.
Prescription drugs and medicines covered under this medical set of benefits include:

- Drugs and Biologicals. Drugs and biologicals approved by the U.S. Food and Drug Administration. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.
- Intravenous Administration. Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).

Not Covered (some of these may be covered under your prescription drug plan). Your medical benefits do not provide coverage for:

- Insulin. This is covered under your prescription drug plan.
- Prescription drugs and devices used to treat nicotine dependence. You are also not covered for psychotherapy, and x-ray and lab services related to nicotine dependence.

- Prescription drugs that are not FDA- approved.

PREVENTIVE CARE

Covered: Your benefits include coverage for preventive care such as:

- Gynecological examinations.
- Mammograms.
- Medical evaluations related to nicotine dependence.
- Pap smears.
- Physical examinations.
- Preventive items and services including, but not limited to:
    - Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);
    - Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Service Administration (HRSA); and
    - Preventive care and screenings for women provided for in guidelines supported by the HRSA.
- Diagnostic screening for prostate cancer, including diagnostic examination, digital rectal examination, prostate- specific antigen test, and bone scan if medically indicated.
- Well-child care including immunizations.

Service Maximum:

- One routine physical examination per benefit year.
- One routine mammogram per benefit year.
- One routine gynecological examination per benefit year.
- One diagnostic screening for prostate cancer, including digital rectal examination and prostate-specific antigen (PSA) test, for:
    - asymptomatic men aged 50 and older;
    - men 45 and older who are at a high risk for prostate cancer.

  This limitation does not apply to men of any age with a history of prostate cancer, who are covered for medically indicated testing at intervals recommended by a physician.

Not Covered: Your benefits do not include coverage for:

- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.

PROSTHETIC DEVICES

Covered: Your benefits provide coverage for devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.

Also covered are braces, which are rigid or semi-rigid devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Not Covered: Your benefits do not provide coverage for:

- Devices such as eyeglasses and air conduction hearing aids or examinations for their prescription or fitting.
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

RECONSTRUCTIVE SURGERY

Covered: Your benefits provide coverage for reconstructive surgery primarily intended to restore function lost or impaired as the result of an illness, injury, or a birth defect (even if there is an incidental improvement in physical appearance) including breast reconstructive surgery following mastectomy. Breast reconstructive surgery includes the following:

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

RESIDENTIAL TREATMENT: Your benefits include coverage for the following:

Alcoholism Treatment.

Covered: Your benefits include coverage for treatment in a residential treatment facility, only on an intensive outpatient basis, or for partial hospitalization treatment, or for treatment that is provided as an inpatient at an acute level of care requiring medically monitored 24-hour registered nursing care under the supervision of a medical director.

Not Covered: Treatment received in a residential treatment facility, except as described under Covered.

Chemical Dependency Treatment.

Covered: Your benefits provide coverage for treatment for a condition with physical or psychological symptoms produced by the habitual use of certain drugs as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised (DSM-IV-R)* or subsequent revisions.

However, for treatment in a residential treatment facility, benefits are available only on an intensive outpatient basis, or for partial hospitalization treatment, or for treatment that is provided as an inpatient at an acute level of care requiring medically monitored 24-hour registered nursing care under the supervision of a medical director.

Mental Health Services. For treatment in a residential treatment facility, benefits are available only on an intensive outpatient basis, or for partial hospitalization treatment, or for treatment that is provided as an inpatient at an acute level of care requiring medically monitored 24-registered nursing care under the supervision of a medical director.

SELF-HELP PROGRAMS

Not Covered: Your benefits do not provide coverage for self-help and self-cure products or drugs.

SLEEP APNEA TREATMENT

Covered: Your benefits do provide coverage for obstructive sleep apnea diagnosis and treatments.

Not Covered: Your benefits do not provide coverage for treatment for snoring without a diagnosis of obstructive sleep apnea.

SPEECH THERAPY

Covered: Your benefits do provide coverage for rehabilitative speech therapy services when related to a specific illness, injury, or impairment and involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.

Not Covered: Your benefits do not provide coverage for:

- Speech therapy services not provided by a licensed or certified speech pathologist.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

SURGERY

Covered. Your benefits provide coverage for the following:

- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.

TEMPOROMANDIBULAR JOINT DISORDER (TMD)

Covered. Your benefits provide coverage for the treatment of temporomandibular joint disorder.

Not Covered: Your benefits do not provide coverage for dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

TRANSPLANTS

Covered: Your benefits include coverage of transplants for:

- Certain bone marrow/stem cell transfers from a living donor.
- Heart.
- Heart and lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Simultaneous pancreas/kidney.
- Small bowel.

Donation of an organ is usually covered by the recipient's medical benefits plan. However, if donor charges are excluded by the recipient's plan, and you are a donor, the charges will be covered by this set of benefits.

Not Covered: Your benefits do not include coverage for:

- Expenses of transporting a living donor.
- Expenses related to the purchase of any organ.
- Services or supplies related to mechanical or non-human organs associated with transplants.
- Transplant services and supplies not listed in this section including complications.

TRAVEL OR LODGING COSTS

Not Covered. Your benefits do not provide coverage for travel or lodging costs.

VISION SERVICES ***(For Pediatric Vision Services benefit guidance, see FEDVIP supplemental vision plan)***

Covered: Your benefits include coverage for vision examinations but only when related to an illness or injury.

Not Covered: Your benefits do not include coverage for the following:

- Surgery to correct a refractive error (i.e. when the shape of your eye does not bend light correctly resulting in blurred images).
- Eyeglasses or contact lenses, including charges related to their fitting.
- Prescribing of corrective lenses.

- Eye examinations for the fitting of eyewear.
- Routine vision examinations.

WIGS OR HAIRPIECES
Not Covered. Your benefits do not provide coverage for wigs or hairpieces.

X-RAY and LABORATORY SERVICES
Covered: Your benefits include coverage for tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under Radiology Guidelines and Pathology and Laboratory Guidelines.

Specialty Drugs

SPECIALTY DRUGS
Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. They may not be available through a mail order drug program. Specialty drugs may be covered under your prescription drug plan or under this medical set of benefits, depending on whether you administer them yourself or your physician administers them.

MEDICAL BENEFITS PLAN
Covered: Your benefits provide coverage for the following:
- Office-Administered Specialty Drugs. Specialty drugs associated with an office procedure or that require skilled administration (e.g., intravenous therapy).
- Prescription Maximum: A 30-day supply.

Not Covered: Your benefits do not provide coverage for the following:
- Self-Administered Specialty Drugs. Specialty drugs that are self- administered. These are covered under your prescription drug plan.

PRESCRIPTION DRUG PLAN
Covered: Your benefits provide coverage for:
- Self-Administered Specialty Drugs.
- Prescription Maximum: A 30-day supply.

Not Covered: Your benefits do not provide coverage for:

Office-Administered Specialty Drugs.

Prescription Drug Plan

You are covered for most prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription" and meet all of the following criteria:
- The prescription drug is FDA-approved or an FDA equivalent and has the same name as the FDA-approved drug.
- Prescribed by a practitioner who is legally authorized to prescribe.
- Dispensed by a recognized licensed retail pharmacy, through the specialty pharmacy program, or through a mail order drug program.
- Drugs that are medically necessary for your condition.

Drugs classified by the FDA as Drug Efficacy Study Implementation (DESI) drugs may also be covered. Covered drugs are limited to those taken orally, absorbed through the skin, and certain injected prescription drugs. Devices and implants are never covered.

BRAND NAME PRESCRIPTION DRUGS
Covered: Benefits are provided for coverage of prescription drugs patented by the original manufacturer.

- Prescription Maximum**:**
  - Retail Non-Maintenance Prescriptions. A 30-day supply.
  - Retail Maintenance Prescriptions. A 90- day supply.
  - Mail Order Non-Maintenance Prescriptions. A 30-day supply.
  - Mail Order Maintenance Prescriptions. A 90-day supply.

CHEMICAL DEPENDENCY DRUGS
Covered. Benefits are provided for coverage of chemical dependency drugs.

CONTRACEPTIVES
Covered: Benefits are provided for coverage of contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches.
Not Covered: Benefits are not provided for coverage of the following:

- Contraceptive medical devices, such as intrauterine devices and diaphragms.
- Implanted contraceptives.
- Injected contraceptives.

CONVENIENCE PACKAGING
Not Covered: If the cost of the convenience packaged drug exceeds what the drug would cost if purchased in its normal container, the convenience packaged drug is not covered.

COSMETIC DRUGS
Not Covered: Prescription drugs that are primarily to improve your natural appearance are not covered.

DRUGS THAT ARE LOST, DAMAGED, STOLEN, OR USED INAPPROPRIATELY
Not Covered. Benefits are not provided for coverage of drugs that are lost, damaged, stolen, or used inappropriately.

DRUGS YOU ABUSE
Not Covered: Drugs determined to be abused or otherwise misused by you are not covered.

GENERIC PRESCRIPTION DRUGS
Covered: Benefits are provided for prescription drugs with active therapeutic ingredients chemically identical to a brand name drug. These drugs are often available at a lower cost than their brand- name equivalent.

- Prescription Maximum:
  - Retail Non-Maintenance Prescriptions. A 30-day supply.
  - Retail Maintenance Prescriptions. A 90- day supply.
  - Mail Order Non-Maintenance Prescriptions. A 30-day supply.
  - Mail Order Maintenance Prescriptions. A 90-day supply.

IMMUNIZATION AGENTS
Covered: Benefits are provided for coverage of immunizations received at a retail pharmacy,

excluding travel immunizations.
Not Covered: Benefits are not provided for coverage of the following:

- Biological products for allergy immunization, or biological serum, blood, blood plasma, and other blood products or fractions.
- Immunizations performed solely for travel.

IMPOTENCE DRUGS
Covered: Benefits are provided for coverage of impotence drugs if the condition is the result of a physical illness or injury.

INFERTILITY DRUGS
Not Covered: Benefits are not provided for coverage of prescription drugs necessary to treat male or female infertility.

INSULIN AND DIABETIC SUPPLIES
Covered: Benefits are provided for insulin and diabetic supplies including needles, syringes, test strips, and lancets.

IRRIGATION SOLUTIONS AND SUPPLIES
Not Covered. Benefits are not provided for irrigation solutions or supplies.

NUTRITIONAL AND DIETARY SUPPLEMENTS
Covered: Benefits are provided for coverage of prenatal vitamins.
Not Covered: Benefits are not provided for most prescription and non-prescription nutritional and dietary supplements including, but not limited to:

- Special dietary formulas.
- Herbal products.
- Fish oil products.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

OVER-THE-COUNTER PRODUCTS
Not Covered: Benefits are not provided for most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products prescribed by a physician may be covered.

PRESCRIPTION DRUGS THAT ARE NOT FDA APPROVED
Not Covered. Benefits are not provided for coverage of prescriptions that are not FDA approved.

PREVENTIVE ITEMS AND SERVICES
Covered: Benefits are provided for preventive items and services received at a licensed retail pharmacy, including certain items or services recommended with an "A" or "B" rating by the United States Preventive Services Task Force, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

SALES TAX
Covered: If you purchase a covered prescription drug that is subject to a state sales tax, the sales tax amount is covered.

SELF-ADMINISTERED INJECTABALE DRUGS

Covered: Self-administered injectable drugs are generally covered under your prescription drug plan. However, there are exceptions where self-administered injectable drugs may be covered under your medical benefits plan (e.g., drugs given in the muscle or through a vein).

SELF-HELP DRUGS

Not Covered: Self-help or self-cure products or drugs are not covered.

THERAPEUTIC DEVICES OR MEDICAL APPLIANCES

Not Covered: Benefits will not be provided for therapeutic devices or medical appliances including hypodermic needles or syringes and home/durable medical equipment. This exclusion does not apply to diabetic equipment and supplies including needles and syringes for insulin.

WEIGHT REDUCTION DRUGS

Not Covered: Regardless of whether weight reduction is medically appropriate, benefits will not be provided for weight reduction drugs.

PRESCRIPTION PURCHASES OUTSIDE THE UNITED STATES

To qualify for benefits for prescription drugs purchased outside the United States, all of the following requirements must be met:

- You are injured or become ill while in a foreign country.
- The prescription drug's active ingredient and dosage form are FDA-approved or an FDA equivalent and has the same name and dosage form as the FDA- approved drug's active ingredient.
- The prescription drug would require a written prescription by a licensed practitioner if prescribed in the U.S.
- You provide acceptable documentation that you received a covered service from a practitioner or hospital and the practitioner or hospital prescribed the prescription drug.

QUANTITY LIMITATIONS

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription. Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount prescribed by your physician. In addition, coverage for certain drugs is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered.

REFILLS

To qualify for refill benefits, all of the following requirements must be met:

- Sufficient time has elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner.
- The refill is not to replace medications that have been lost, damaged, stolen, or used inappropriately.
- The refill is for use by the person for whom the prescription is written (and not someone else).
- The refill does not exceed the amount authorized by your practitioner.
- The refill is not limited by state law.

You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time. If traveling within the United States, the refill amount will be subject to any applicable quantity limits under this coverage. If traveling outside the United States, the refill amount will not exceed a 90-day supply.

3. General Conditions of Coverage, Exclusions, and Limitations

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services or supplies.

CONDITIONS OF COVERAGE

Medically Necessary: A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in Details – Covered and Not Covered may be excluded if it is not medically necessary in the circumstances. Even though a provider may recommend a service or supply, it may not be medically necessary.

A medically necessary health care service is one that a provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and is:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
  - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
  - Any other relevant factors.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury, or disease.

An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, the least costly alternative may be covered.

GENERAL EXCLUSIONS

Even if a service, supply, device, or drug is listed as otherwise covered in Details – Covered and Not Covered, it is not eligible for benefits if any of the following general exclusions apply.

Investigational or Experimental: You are not covered for a service, supply, device, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine. To determine investigational or experimental status, technical criteria including but not limited to whether a service, supply, device, or drug meets these criteria:

- It has final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning its effect on health outcomes.
- It improves the net health outcome.
- It is as beneficial as any established alternatives.
- The health improvement is attainable outside the investigational setting.

Complications of a Noncovered Service

You are not covered for a complication resulting from a noncovered service, supply, device, or drug.

However, this exclusion does not apply to the treatment of complications resulting from smallpox vaccinations when payment for such treatment is not available through workers' compensation or government-sponsored programs.

Nonmedical Services
You are not covered for telephone consultations, charges for missed appointments, charges for completion of any form, or charges for information.

Personal Convenience Items
You are not covered for items used for your personal convenience, such as:

- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of illness or injury (including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

Provider Is Family Member
You are not covered for a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse or domestic partner) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of his or her practice.

Covered by Other Programs or Laws
You are not covered for a service, supply, device, or drug if:

- You are entitled to claim benefits from a governmental program (other than Medicaid).
- Someone else has the legal obligation to pay for services and without this group health set of benefits, you would not be charged.

Workers' Compensation
You are not covered for services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization.

4. Glossary

The definitions in this section are terms that are used in various sections of this coverage manual. A term that appears in only one section is defined in that section.

Accidental Injury. An injury, independent of disease or bodily infirmity or any other cause, that happens by chance and requires immediate medical attention.

Admission. Formal acceptance as a patient to a hospital or other covered health care facility for a health condition.

Autism Spectrum Disorder. A complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive and stereotyped patterns of behavior.

Benefits. Medically necessary services or supplies that qualify for payment under this group health plan.

Compounded Drugs. Compounded prescription drugs are produced by combining, mixing, or altering ingredients by a pharmacist to create an alternate strength or dosage form tailored to the specialized medical needs of an individual patient when an FDA-approved drug is unavailable or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs.

Domestic Partner. An unmarried person of the same sex as the plan member who has signed an affidavit of domestic partnership with the plan member.

Habilitative Services. Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Illness or Injury. Any bodily disorder, bodily injury, disease, or mental health condition, including pregnancy and complications of pregnancy.

Inpatient. Diagnostic, therapeutic, or other health care services received while admitted to an approved health care facility, other than those received in an outpatient setting; or a person receiving such services.

Maintenance. An industry-wide classification for prescription drug treatments to control specific, ongoing health conditions.

Medical Appliance. A device or mechanism designed to support or restrain part of the body (such as a splint, bandage or brace); to measure functioning or physical condition of the body (such as glucometers or devices to measure blood pressure); or to administer drugs (such as syringes).

Medicare. The federal government health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and for individuals of any age entitled to monthly disability benefits under Social Security or the Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Outpatient. Services received, or a person receiving services, in the outpatient department of a hospital, an ambulatory surgery center, or the home.

Services or Supplies. Any services, supplies, treatments, devices, or drugs, as applicable in the context of this coverage manual, that may be used to diagnose or treat a medical condition.

Specialty Drugs. Drugs that are typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. Some specialty drugs may be taken orally, but others may require administration by injection, infusion, or inhalation. Specialty drugs may not be available from a retail pharmacy.

Spouse. A husband or wife as the result of a marriage that is legally recognized in South Dakota.

X-ray and Lab Services. Tests, screenings, imagings, and evaluation procedures identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under Radiology Guidelines and Pathology and Laboratory Guidelines.