

Your 2010 Medical Benefit Chart
PFFS Plan 0
Maine State Employees Health Insurance Program
Effective 01/01/2010

Covered Services	What you must pay for these covered services
Inpatient Services	
<p>Inpatient hospital care</p> <p>Hospital days are unlimited. Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy, and speech therapy services. • <i>Under certain conditions, the following types of transplants are covered:</i> Corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services. 	<p>For Medicare-covered hospital stays:</p> <p>\$0 copay per admission</p> <p>No limit to the number of days covered by the plan each benefit period.</p>

Covered Services	What you must pay for these covered services
<p>Inpatient mental health care</p> <p>Includes mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital.</p>	<p>For Medicare-covered Hospital Stays:</p> <p>\$0 copay per admission</p>
<p>Skilled nursing facility care</p> <p>Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A “benefit period” begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.</p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services ordinarily provided by SNF’s. • Use of appliances such as wheelchairs ordinarily provided by SNF’s. • Physician services. <p>No prior Hospital stay required.</p>	<p>For Medicare-covered SNF stays:</p> <p>\$0 copay per admission</p>

Covered Services

What you must pay for these covered services

Inpatient services covered when the hospital or SNF days aren't or are no longer, covered

Covered services include:

- Physician services.
- Tests (like X-ray or lab tests).
- X-ray, radium, and isotope therapy including technician materials and services.
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.
- Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
- Physical therapy, speech therapy, and occupational therapy.

After your SNF day limits are used up, the plan will still pay for covered physician services and other medical services outlined in this benefit chart.

Home health agency care

Covered services include:

- Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and thirty-five or fewer hours per week.)
- Physical therapy, occupational therapy, and speech therapy.
- Medical social services.
- Medical equipment and supplies.

\$0 copay for Medicare-covered home health visits

Covered Services

What you must pay for these covered services

Hospice care

You may receive care from any Medicare-certified hospice program. Original Medicare plan (rather than our plan) will pay the hospice provider for the services you receive. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan.

Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare.
- Home care.
- Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan. You pay \$0 copay for the one time only hospice consultation.

Outpatient Services

Physician services, including doctor office visits

Covered services include:

- Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center.
- Consultation, diagnosis, and treatment by a specialist.
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment.
- Telehealth office visits including consultation, diagnosis and treatment by a specialist.
- Second opinion by another plan provider prior to surgery.
- Outpatient hospital services.
- Non-routine dental (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation).

\$0 copay per visit to a primary care physician (PCP) for Medicare-covered services
\$0 copay per visit to a specialist for Medicare-covered services

Covered Services	What you must pay for these covered services
<p>Physician services, including doctor office visits (cont)</p> <ul style="list-style-type: none"> Treatments of neoplastic cancer disease or services that would be covered when provided by a doctor. <p>Excess Charge- Providers who do not accept Medicare assignment may bill up to 15% above the Medicare approved amount.</p>	<p>Excess charge- Plan covers up to 115% of Medicare allowed amount if the provider does not accept Medicare assignment.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Manual manipulation of the spine to correct subluxation. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. 	<p>\$0 copay for each Medicare-covered visit</p>
<p>Podiatry services</p> <ul style="list-style-type: none"> Treatment of injuries and disease of the feet (such as hammer toe or heel spurs). Medicare-covered routine foot care for member with certain medical conditions affecting the lower limbs. Foot exams: A foot exam is covered every six 6 months for people with diabetic peripheral neuropathy and loss of protective sensations. 	<p>\$0 copay for each Medicare-covered visit</p>
<p>Outpatient mental health care (including Partial Hospitalization Services)</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>\$0 copay for each Medicare-covered individual or group therapy visit</p>

Covered Services	What you must pay for these covered services
<p>Outpatient substance abuse services</p>	<p>\$0 copay for each Medicare-covered individual or group therapy visit</p>
<p>Outpatient surgery (Includes services provided at ambulatory surgical centers.)</p> <p>Facilities where surgical procedures are performed; and, the patient is released the same day.</p>	<p>\$0 copay for each Outpatient Hospital Facility or Ambulatory Surgical Center visit for surgery</p>
<p>Ambulance services</p> <p>Covered ambulance services include fixed wing, rotary wing and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.</p> <p>Ambulance service is not covered for physician office visits.</p>	<p>\$0 copay for Medicare-covered ambulance services</p>
<p>Emergency care</p> <ul style="list-style-type: none"> This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. <p>Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition.</p>	<p>\$0 copay for each Medicare-covered emergency room visit</p>

Covered Services	What you must pay for these covered services
<p>Urgently needed care</p> <ul style="list-style-type: none"> • Urgent care is available on a world-wide basis. • If you are outside of the service area for your plan, your plan covers urgently needed care, including urgently required renal dialysis. 	<p>\$0 copay for each Medicare-covered urgently needed care visit</p>
<p>Comprehensive Outpatient Rehabilitation Facility (CORF) services</p> <p>(physical therapy, occupational therapy, cardiac rehabilitation, pulmonary rehabilitation and speech and language therapy)</p> <p>Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris, have had a heart valve repair/replacement, angioplasty or coronary stenting, or have had a heart or heart-lung transplant.</p>	<p>\$0 copay per visit for Medicare-covered outpatient rehabilitation services</p>
<p>Durable medical equipment (DME) and related supplies</p> <p>This includes but not limited to, wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>\$0 copay on all Medicare-covered DME and related supplies</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace a body part or function. These include but not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” for more detail.</p>	<p>\$0 copay on all Medicare-covered Prosthetic and related supplies</p>

Covered Services	What you must pay for these covered services
<p>Diabetes self-monitoring training and supplies</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per year of therapeutic shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. • Self-management training is covered under certain conditions. • <i>For persons at risk of diabetes:</i> fasting plasma glucose tests are covered. 	<p>For Medicare-covered services:</p> <p>\$0 copay for a 30 day supply on each purchase of glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors</p> <p>\$0 copay for blood glucose monitor and therapeutic shoes</p> <p>\$0 copay for self-management training</p> <p>\$0 copay for fasting plasma glucose tests covered up to twice a year</p>
<p>Medical nutrition therapy</p> <p>For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p>\$0 copay for each Medicare-covered visit</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • X-rays. 	<p>\$0 copay for each Medicare-covered x-ray visit</p>

Covered Services	What you must pay for these covered services
<p>Outpatient diagnostic tests and therapeutic services and supplies (cont)</p> <ul style="list-style-type: none"> • Complex diagnostic tests and x-rays. • Radiation therapy. • Laboratory tests. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. <p>Diagnostic tests and x-rays are considered complex and include heart catheterizations, sleep studies, computer tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.</p>	<p>\$0 copay for Medicare-covered complex diagnostic test and x-ray services</p> <p>\$0 copay for each Medicare-covered radiation therapy & chemotherapy treatment</p> <p>\$0 copay for Medicare-covered clinical/diagnostic lab test</p> <p>\$0 copay for supplies</p> <p>\$0 copay per pint of blood</p>
<p>Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • Eye Exams: An eye exam to check for diabetic retinopathy once every twelve (12) months. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. 	<p>For Medicare-covered services:</p> <p>\$0 copay for exams to diagnose and treat diseases of the eye.</p> <p>\$0 copay for glaucoma screening</p> <p>\$0 copay for glasses/ contacts following cataract surgery</p>

Covered Services

What you must pay for these covered services

Preventive Care and Screening Tests

Abdominal aortic aneurysm screening

A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.

\$0 copay for Medicare-covered screening

Bone mass measurements

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

\$0 copay for visits to primary care physicians (PCP) for Medicare-covered bone mass measurement

\$0 copay for visits to physician specialists for Medicare-covered bone mass measurement

Colorectal screening

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.
- Fecal occult blood test, every 12 months.

For people at high risk of colorectal cancer, the following are covered:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months.

For people not at high risk of colorectal cancer, the following is covered:

- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.

\$0 copay for visits to primary care physicians (PCP) for Medicare-covered screenings

\$0 copay for visits to physician specialists for Medicare-covered screenings

Covered Services	What you must pay for these covered services
<p>Immunizations</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine. • Other vaccines if you are at risk. <p>If Part D prescription drug coverage is included with your medical plan, we also cover some vaccines under our outpatient prescription drug benefit.</p>	<p>\$0 copay for Medicare-covered immunizations</p>
<p>Mammography screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older. 	<p>\$0 copay for Medicare-covered screening exams</p>
<p>Pap test, pelvic exams, and clinical breast exam</p> <p>Covered services include:</p> <p>For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months.</p> <p>If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.</p>	<p>\$0 copay for Medicare-covered screening exams</p>
<p>Prostate cancer screening exams</p> <p>For men age 50 and older, the following are covered once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam. • Prostate Specific Antigen (PSA) test. 	<p>\$0 copay for visits to primary care physicians (PCP) for Medicare-covered screening exams</p> <p>\$0 copay for visits to physician specialists for Medicare-covered screening exams</p>

Covered Services	What you must pay for these covered services
<p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) every five years.</p>	<p>\$0 copay for Medicare-covered tests</p>
Other Services	
<p>Physical exams</p> <p>Routine physical exams (limited to one exam per year) are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are not required by third-party (i.e., insurance companies, business establishments, governmental agencies).</p> <p>Routine labs and x-rays ordered in conjunction with the physical exam are covered under “<u>Outpatient diagnostic tests and therapeutic services and supplies</u>” unless otherwise specified in this benefit chart.</p>	<p>\$0 copay for visits to primary care physicians (PCP)</p> <p>\$0 copay for visits to physician specialists</p>
<p>Dialysis (Kidney)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). 	<p>For Medicare-covered services:</p> <p>\$0 copay for outpatient dialysis</p> <p>Inpatient hospital copay applies to inpatient dialysis.</p> <p>\$0 copay for self-dialysis training</p> <p>\$0 copay for home dialysis equipment and supplies</p>
<p>Medicare Part B prescription drugs</p> <p>“Drugs” includes substances that are naturally present in the body, such as blood clotting factors.</p> <p>Drugs that usually are not self-administered by the patient</p>	<p>\$0 copay for Medicare Part B covered drugs.</p>

Covered Services**What you must pay for these covered services****Medicare Part B prescription drugs (cont)**

- and are injected while receiving physician services. This plan also covers some drugs that are “usually not self-administered” even if you inject them at home.
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan.
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.

If Part D prescription drug coverage is included with your medical plan, please refer to your Evidence of Coverage for information on your Part D prescription drug benefits.

\$0 copay for Medicare-covered chemotherapy drugs.

Additional Benefits**Hearing services**

- Routine hearing exams are covered once every two years.
- Hearing aids.

Routine hearing exams are limited to a \$50 benefit maximum.

\$0 copay for routine hearing exams.

\$50 benefit maximum is waived for this plan

No coverage for hearing aids.

Covered Services	What you must pay for these covered services
<p>Routine Vision Care</p> <ul style="list-style-type: none"> • Routine vision exams • Eye wear <p>Routine vision exams are limited to a \$50 benefit maximum.</p>	<p>\$0 copay for routine vision exams</p> <p>\$50 benefit maximum is waived for this plan</p> <p>No coverage for routine eye wear.</p>
Health and Wellness education programs	
<p>SilverSneakers®</p> <p>You can enroll in this program. A fitness plan designed especially for Medicare-eligible individuals. SilverSneakers® includes:</p> <ul style="list-style-type: none"> • A complimentary basic membership in a participating fitness center in your area. You can use all the services available to fitness center members with a basic membership, such as steam and sauna rooms, exercise equipment, and SilverSneakers® classes custom-designed for all levels of fitness. • Opportunities to join in fitness promotions and health education seminars. <p>There is not a separate charge for this program, as long as you only use services available with basic fitness center memberships.</p> <p>After you enroll in this Medicare Advantage plan, you will receive a brochure that shows the participating fitness centers in your area and describes how to enroll in SilverSneakers.</p> <p>Contact Customer Service for more information on this program, or visit www.SilverSneakers.com.</p>	<p>\$0 copay for the Silver Sneakers fitness benefit</p>
<p>Smoking Cessation (Counseling to quit smoking)</p> <p>Up to eight (8) face-to-face visits in a twelve (12) month period if you are diagnosed with an illness caused or complicated by tobacco use; or, you take a medication that is affected by tobacco. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.</p>	<p>\$0 copay for each Medicare-covered visit</p>

Covered Services	What you must pay for these covered services
<p>Foreign travel inpatient, emergency and urgently needed care</p> <p>Emergency or urgent care services while traveling outside the United States during a temporary absence of less than 6 months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition.</p> <ul style="list-style-type: none"> • Emergency outpatient care. • Urgent care. • Inpatient care (60 days per lifetime, 80% to \$50,000 lifetime maximum for inpatient care). • Non-emergent care. 	<p>\$0 copay for Emergency Care</p> <p>\$0 copay for Urgent Care</p> <p>\$250 deductible and 20% coinsurance for inpatient care until lifetime maximum is reached</p> <p>Not covered for non-emergent care.</p>
<p>Annual Out of Pocket Maximum</p> <p>All coinsurance, copayments and deductibles for Medicare-covered services listed in this benefit chart are accrued toward the medical plan out of pocket maximum with the exception of routine vision, routine hearing, the foreign travel emergency and urgently needed care copays specific to foreign travel and the foreign travel inpatient deductible and coinsurance. Medicare part D Prescription drug deductibles, copays and cost shares do not apply to the medical plan out of pocket maximum.</p>	<p>\$0</p>

You must receive all services (except emergency care) from doctors, specialists and hospitals that agree to accept the plan terms and conditions of payment in order to have those services covered by this plan.

ADDITIONAL SERVICES Not Covered by Medicare	
Annual Deductible	\$100
Lifetime Maximum	\$1,000,000
<p>Chiropractic Services</p> <p>Benefits are provided for ancillary treatment such as massage therapy, heat and electro-stimulation in conjunction with an active course of treatment. Benefits are not provided for maintenance therapy for chronic conditions.</p>	20% coinsurance after deductible is met
<p>Acupuncture</p> <p>The services of a licensed acupuncturist or Doctor of Chinese Medicine for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.</p> <p>Chinese herbs and supplements excluded.</p>	20% coinsurance after deductible is met
<p>Temporomandibular Joint Syndrome (TMJ)</p> <p>Coverage is provided for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint (jaw hinge). Coverage is limited to surgery or injections of the temporomandibular joint, physical therapy, or other medical treatments</p> <p><i>Benefits are not provided for any temporomandibular joint syndrome services not listed as covered in the Covered Services section. Coverage is not provided for any procedure or device that alters the vertical relationship of the teeth or the relation of the mandible to the maxilla. Dental services related to TMJ are not covered.</i></p>	20% coinsurance after deductible is met

<p>Stockings</p> <p>Benefits are provided for stockings such as Linton, Jobst and Sigvaris stockings only when provided for post-surgical use or when prescribed for circulatory diseases.</p>	<p>20% coinsurance after deductible is met</p>
<p>Wigs/Hairpieces</p> <p>Only covered for certain diseases, injuries, congenital or developmental anomalies, or previous therapeutic processes, resulting in temporary or permanent hair loss. Must be ordered by a physician.</p> <p>Only covered for certain diseases, injuries, congenital or developmental anomalies, or previous therapeutic processes, resulting in temporary or permanent hair loss. Must be ordered by a physician. Limit two per calendar year.</p> <p>Traumatic or surgical scalp avulsion, burns, alopecia areata or totalis. Medical conditions documented by tests and other diagnostic measures resulting in permanent or temporary hair loss. Conditions or injuries being actively treated with an accepted and covered treatment that have resulted in temporary hair loss.</p> <p>Note: If covered, wigs/hairpieces are considered to be a prosthetic and would be subject to any product-specific calendar year limits for prosthetics.</p> <p>The following is a list of exclusions for wigs or hairpieces due to:</p> <ul style="list-style-type: none"> • Aging. • Male pattern baldness or premature old age. • Medical conditions which cannot be documented by tests and other diagnostic measures resulting in hair loss. • The cleaning and maintenance of hairpieces. 	<p>20% coinsurance after deductible is met</p>

Dental Services

Dental Services Benefits are provided only for the following teeth and jaw services:

- Setting a jaw fracture;
- Removing a tumor or cyst (but not a root cyst);
- Removing impacted or unerupted teeth in a non-hospital or non-rural health center setting;
- Repairing or replacing dental prostheses damaged by an accidental bodily injury;
- Treating accidental bodily injury to natural teeth;
- Emergency stabilization treatment for accidental injury to natural teeth if initiated and completed within 72 hours of the injury or accident;
- Biopsy and excision of a lesion;
- Gingivectomy or gingoplasty (per quadrant per tooth);
- Gingival flap procedure (including root planning per quadrant);
- Osseous surgery (including flap entry and closure per quadrant);
- Osseous surgery or graft; single site or multiple sites (including flap entry, closure, and donor sites);
- Pedicle soft tissue graft;
- Free soft tissue graft (including donor site);
- Apically repositioned flap procedure;
- Excision of partially or completely unerupted teeth;
- Excision of a tooth root without the extraction of the entire tooth;
- Suturing of dental surgical incision;
- Cancer-related dental services; and
- Other incision or excision of the gums or tissues of the mouth.
- Some of the services listed above may also be covered under your dental plan.

20% coinsurance after deductible is met