

Traditional Dental Coverage

AN IMPORTANT PART OF YOUR HEALTH CARE PACKAGE

Regular preventive dental care is an important part of staying healthy. That's why CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice)*** are pleased to offer Traditional Dental coverage, which allows you the complete freedom to see any dentist you choose.

ADVANTAGES OF THE PLAN

- **Freedom of Choice** – With Traditional Dental coverage, you have the freedom to see any dentist. So, whether you're at work, at home, on vacation or just traveling, you can be sure that your dental coverage will travel with you.
- **Preventive Care and more** – Benefits for you and your family include regular preventive care, X-rays, dental surgery and more. A summary of your benefits is available on the opposite side of this page. (Additional coverage for orthodontia may be included – ask your benefits manager for details).
- **Large Network** – You have a choice of over 3,800 dentists in Maryland, Virginia and Washington D.C. who participate with CareFirst and CareFirst BlueChoice. This means that you can see a dentist where you live, where you work, or anywhere in between.
- **Opportunity to Reduce Costs** – If you see a participating dentist, you will incur lower out-of-pocket costs for all dental services and you will have no claim forms to file.

Participating dentists have agreed to accept CareFirst's or CareFirst BlueChoice's allowed benefit as payment in full for covered services. Once you meet your deductible and coinsurance, you won't be faced with additional expenses. You will not be balance billed!

- **Out-of-Network Benefit** – You can receive care from a non-participating dentist and have the same level of coverage; however, you may be subject to higher out-of-pocket costs and balance billing.
- **Nationwide emergency coverage** – Whether you are in Baltimore or Boston, Laurel or Los Angeles, you have coverage for the dental services you need, when you need them.

FREQUENTLY ASKED QUESTIONS

How much will I have to pay for dental services?

The chart on the opposite side of this page gives you an overview of many of the covered services, along with the percentage of what you will pay for each class of services.

Is there a lot of paperwork?

There is no paperwork when you use a dentist who participates with CareFirst or CareFirst BlueChoice. If you see a non-participating dentist, you will be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for those services covered under your plan.

Who can I call with questions about my dental plan?

Call CareFirst BlueCross BlueShield toll free at (866) 891-2802.

Looking for a Dentist?



Connect to CareFirst www.carefirst.com
Regional Traditional Dental - DT Directory

Summary of Benefits

| BENEFITS | YOU PAY |
|--|--|
| DEDUCTIBLE APPLIES TO CLASSES II, III & IV | \$50 Individual \$150 Family |
| ANNUAL MAXIMUM (CLASSES I - IV) | \$1,500 |
| PREVENTIVE & DIAGNOSTIC SERVICES (CLASS I) | COINSURANCE |
| <ul style="list-style-type: none"> • Oral Exams (two per benefit period) • Prophylaxis (two cleanings per benefit period) • Bitewing X-rays • Full mouth X-ray or panograph and bitewing X-ray combination and one cephalometric X-ray (once per 36 months) • Fluoride treatments (two per benefit period per member, age requirements may apply) • Sealants on permanent molars (once per tooth per 36 months per member, age requirements may apply) • Space maintainers (once per 60 months) • Palliative emergency treatment | No charge from participating dentist** |
| BASIC SERVICES (CLASS II) | COINSURANCE |
| <ul style="list-style-type: none"> • Direct placement fillings using approved materials (one filling per surface per 12 months) • Periodontical scaling and root planing (once per 24 months, one full mouth treatment) • Simple extractions | 20% of Allowed Benefit after deductible** |
| MAJOR SERVICES - SURGICAL (CLASS III) | COINSURANCE |
| <ul style="list-style-type: none"> • Surgical periodontic services including osseous surgery, mucogingival surgery and occlusal adjustments (once per 60 months) • Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) • Oral surgery (surgical extractions, treatment for cysts, tumor and abscesses, apicoectomy and hemi-section) • General anesthesia rendered for a covered dental service | 20% of Allowed Benefit after deductible** |
| MAJOR SERVICES – RESTORATIVE (CLASS IV) | COINSURANCE |
| <ul style="list-style-type: none"> • Full and/or partial dentures (once per 60 months) • Fixed bridges, crowns, inlays and onlays (once per 60 months) • Denture adjustments and relining (limits apply for regular and immediate dentures) • Recementation of crowns, inlays and/or bridges (once per 12 months) • Repair of prosthetic appliances as required (once in any 12 month period per specific area of appliance) | 50% of Allowed Benefit after deductible** |
| ORTHODONTIC SERVICES (CLASS V)* | COINSURANCE |
| • Benefits for orthodontic services may be available for covered members under age 19 who meet treatment criteria. Covered services are limited to 36 consecutive months of covered services. | 50% of Allowed Benefit to \$800 or \$1,200 lifetime maximum** |

* Coverage for orthodontia may be included—ask your benefits manager for details, including lifetime maximum.

** NOTE: CareFirst and CareFirst BlueChoice payments are based on the CareFirst and CareFirst BlueChoice Allowed Benefit. Participating Dentists accept 100% of the Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

*** The CareFirst BlueChoice Dental Plan is offered in conjunction with Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield, which contracts with participating dentists and provides claims processing and administrative services under the Dental Plan.

These benefits are issued under policy form numbers: VA/CF/DO-DOCS (R. 1/04) • VA/CF/DO-SOB (R. 1/04) • VA/CF/GC-V (9/04) • VA/CF/COC-DEN (9/04) • VA/CF/ELIG (9/04) and any amendments to these forms.

VA/BC/DENTAL RIDER (R. 1/04)

VA/CF/DENTAL RIDER (R. 1/04)

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

PLAN 4

SECTION 4 - LIMITATIONS AND EXCLUSIONS – Dental Contract

(in addition to those found in the Certificate)

4.1 Limitations.

- A. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained
- B. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments and custom denture teeth
- C. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst shall pay as if only one Dentist rendered the service
- D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to Orthodontic Services) (*optional*)
- E. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative

4.2 Exclusions. Benefits will not be provided for:

- A. Replacement of a denture, bridge, or crown as a result of loss or theft
- B. Replacement of an existing denture, bridge, or crown that is determined by CareFirst to be satisfactory or repairable
- C. Replacement of dentures, bridges, or crowns within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the Contract
- D. Treatment or services for temporal mandibular joint disorders including but not limited to radiographs and/or tomographic surveys
- E. Gold foil fillings
- F. Dental implants and the related hardware and surgical services related to the placement of the implant, except when performed as an alternative benefit to a fixed bridge
- G. Dental services in connection with birth defects or mainly for Cosmetic reasons; with the following exceptions:
 - 1. Benefits will be provided for dental services received by the Member due to trauma to whole Sound Natural Teeth only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst, and
 - 2. Benefits will be provided for dental services in connection with birth defects, including cleft lip or cleft palate or both, only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst.
- H. Periodontal appliances
- I. Prescription drugs, including, but not limited to antibiotics administered by the Member, inhalation of nitrous oxide, injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a covered service in the Contract.
- J. Splinting
- K. Nightguards, occlusal guards, or other oral orthotic appliances
- L. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a covered service in the Contract.
- M. Intentional tooth reimplantation or transplantation
- N. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning
- O. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours.
- P. Transseptal fibrotomy or vestibuloplasty
- Q. Orthognathic Surgery or other oral Surgery covered under the Member's medical benefit plan
- R. The repair or replacement of any orthodontic appliance
- S. Any orthodontic services after the last day of the month in which covered services ended except as specifically described in the Certificate of Coverage
- T. Services or supplies that are not Medically Necessary.
- U. Services not specifically shown in the Contract as a Covered Dental Service, even if Medically Necessary
- V. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services)
- W. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist's charges and billed for by them
- X. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services
- Y. Services or supplies that are Experimental or Investigational in nature
- Z. Services, appliances, or supplies related to orthodontic treatment.
(*optional*)

EXCLUSIONS AND LIMITATIONS - CAREFIRST MEDICAL CONTRACT

Only applies to group contracts that include the CareFirst Dental Rider, form # VA/CF/DENTAL RIDER (R. 1/04)

- 10.1 Medical Necessity and Appropriateness.** Benefits will not be provided for services, tests, procedures or supplies which we determine are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. Although a service or supply is listed as covered, benefits will be provided only if it is medically necessary and appropriate in the Member's particular case. A service or supply is medically necessary and appropriate only if, in our judgment it is:
- Necessary and appropriate for the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
 - Consistent with the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
 - The most appropriate supply, treatment or level of service that can be provided safely to the Member and, if the Member is an inpatient, cannot be provided safely on an outpatient basis; and
 - Not primarily for the convenience of the Member or provider. Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by an Eligible Provider. We may consult with professional medical consultants, peer review committees, or other appropriate sources for recommendations on whether the services, supplies, or accommodations a Member receives are Medically Necessary.
- 10.2 Accepted Medical Practice.** Benefits will not be provided for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in our judgment, is experimental, investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment. A service or supply is deemed to be experimental or investigational if:
- A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;
 - It is not in accordance with generally accepted standards of medical practice; or
 - It does not have federal or other required governmental agency approval at the time it is received.
 - This exclusion will not be used, however, to deny Patient Cost when the services for Clinical Trials meet all the requirements under the section entitled "Clinical Trial".
- 10.3 Free Care.** Payment will not be made for services which, if the Member were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill or collect from the patient directly.
- 10.4 Routine Care of Feet.** Benefits will not be provided for any services related to hygiene and preventative maintenance such as trimming of corns, calluses, flat feet, fallen arches, chronic foot strain or partial removal of a nail without the removal of its matrix, in the absence of an underlying health condition.
- 10.5 Dental Care.** Except as provided in the evidence of coverage, benefits will not be provided for any other type of dental care including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth or any other dental services or supplies, unless provided in a separate Rider or Endorsement to the Agreement.
- 10.6 Oral Surgery.** Except as otherwise provided in the evidence of coverage, benefits will not be provided for procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for cosmetic purposes or for correction of malocclusion are excluded.
- 10.7 Cosmetic Services.** Benefits will not be provided for cosmetic surgery (except benefits for Reconstructive Breast Surgery and the treatment of morbid obesity) or other services primarily intended to correct, change or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by the Plan.
- 10.8 Prescription Drugs.** Except as provided in a separate rider or endorsement to the Agreement, benefits will not be provided for prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, except as may be provided in a separate rider or endorsement to the Agreement, even though they may be dispensed or administered in a physician or provider office or facility.
- 10.9 Organ Transplants.** Organ transplant procedures, including complications resulting from any such procedure, services or supplies related to any such procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in your Agreement.
- 10.10 Other Exclusions.** Benefits will not be provided for the following:
- Services or supplies received before the effective date of your coverage under the Agreement.
 - Treatment of sexual dysfunctions or inadequacies except surgical implants for impotence (medical therapy and psychiatric treatment are not covered).
 - Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
 - Weight reduction or obesity treatment, except the surgical treatment of Morbid Obesity.
 - Speech therapy, occupational therapy or physical therapy, unless we determine that your condition is subject to improvement. Coverage does not include nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
 - Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Cardiac rehabilitation programs are covered as described in your Agreement.
 - Services or supplies for the medical or surgical treatment of errors of refraction, such as myopia or hyperopia, including but not limited to radial keratotomy or any like or similar procedures or any complications arising therefrom.
 - Services to the extent they are covered by any governmental unit, except in Veteran's Administration or armed forces facilities for services received, such as for non-service connected disabilities, for which the recipient is liable. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.
 - Services that are beyond the scope of the license of the provider performing the service.
 - Except for covered ambulance services, travel, whether or not recommended by an Eligible Provider.

- k. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
- l. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar persons or groups.
- m. Contraceptive devices.
- n. Assistive reproductive procedures, except when provided in a separate rider or endorsement to your Agreement.
- o. Services solely on court order or as a condition of parole or probation unless approved by the Plan.
- p. Any illness or injury caused by war, declared or undeclared, including armed aggression.
- q. Any service, supply or procedure which is not specifically listed in your Agreement as a covered benefit.
- r. Except as otherwise provided in the evidence of coverage, benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

Not all services and procedures are covered by your benefits contract. This list is a summary and is not intended to itemize every procedure not covered by CareFirst BlueCross BlueShield. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

EXCLUSIONS AND LIMITATIONS - CAREFIRST BLUECHOICE MEDICAL CONTRACT

Only applies to Group contracts that include the CareFirst BlueChoice Dental Rider form # VA/BC/DENTAL RIDER (R. 1/04)

10.1 Coverage Is Not Provided For:

- A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by the Plan.
- B. Services that are Experimental or Investigational as determined by the Plan.
- C. The cost of services that:
 - 1. Are furnished without charge; or
 - 2. Are normally furnished without charge to persons without health insurance coverage;
 - 3. Would have been furnished without charge if you were not covered under the Certificate or under any health insurance.
- D. Services that are not described as covered in the Certificate or that do not meet all other conditions and criteria for coverage, as determined by the Plan. Referral by a Primary Care Physician and/or the provision of services by a Plan Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.
- E. Routine foot care including any service related to hygiene including the trimming of corns or calluses, flat feet, fallen arches, chronic foot strain, or partial removal of a nail without the removal of the matrix except when we determine that Medically Necessary treatment was required because of an underlying health condition such as diabetes, and that all other conditions for coverage have been met.
- F. Dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; or any other dental services or supplies. These services may be covered under a separate rider or endorsement purchased by your Group and attached to the Certificate.
- G. Cosmetic surgery (except benefits for Breast Reconstructive Surgery) or other services primarily intended to correct, change or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by the Plan.
- H. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
- I. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Certificate or a rider or endorsement purchased by your Group and attached to this Certificate.
- J. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- K. Services to reverse voluntary surgically induced infertility such as a reversal of sterilization.
- L. All assisted reproductive technologies (except artificial insemination) including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider or endorsement purchased by your Group and attached to the Certificate.
- M. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; physical conditioning; use of passive or patient-activated exercise equipment.
- N. Treatment for obesity except for the surgical treatment of Morbid Obesity.
- O. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- P. Services furnished as a result of a referral prohibited by law.
- Q. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by the Plan.
- R. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
- S. Acupuncture services except when approved or authorized by the Plan when used for anesthesia.
- T. Any service related to recreational activities. This includes, but is not limited to: sports; games; equestrian; and athletic training. These services are not covered unless authorized or approved by the Plan even though they may have therapeutic value or be provided by a health care provider.
- U. Cardiac rehabilitation programs.
- V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. This exclusion does not apply to care received in a Veteran's Hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.
- W. Except as otherwise provided in the evidence of coverage, benefits will not be provided for Habilitative Services. Benefits for physical therapy, occupational therapy and speech therapy do not include benefits for Habilitative Services.

10.2 Organ and Tissue Transplants. Benefits will not be provided for the following:

- A. Non-human organs and their implantation.
- B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by the Plan.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Any service, supply or device related to a transplant that is not listed as a benefit in the Certificate.

10.3 Inpatient Hospital Services. Benefits will not be provided for the following:

- A. Private room, unless Medically Necessary and authorized or approved by the Plan. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
- B. Non-medical items and convenience items, such as television and phone rentals.
- C. A Hospital admission or any portion of a Hospital admission that had not been authorized or approved by the Plan, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
- D. Private duty nursing unless authorized or approved by the Plan.

10.4 Hospice Benefits. The following are not covered:

- A. Services, visits, medical equipment or supplies that are not included in the Plan-approved plan of treatment.
- B. Services in the Member's home if it is outside the Service Area.
- C. Financial and legal counseling.
- D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.
- E. Chemotherapy or radiation therapy, unless used for symptom control.
- F. Reimbursement for volunteer services.
- G. Domestic or housekeeping services.
- H. Meal on Wheels or similar food service arrangements.
- I. Rental or purchase of renal dialysis equipment and supplies.

10.5 Outpatient Mental Health and Substance Abuse. Benefits will not be provided for:

- A. Psychological testing, unless Medically Necessary, as determined by the Plan, and appropriate within the scope of covered services.
- B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.
- C. Mental retardation, after diagnosis.
- D. Psychoanalysis.

10.6 Inpatient Mental Health and Substance. The following services are excluded:

- A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the Plan's Medical Director.
- B. Custodial Care.
- C. Observation or isolation.

10.7 Emergency Services and Urgent Care. Benefit will not be provided for:

- A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).
- B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.
- C. Charges for Emergency and Urgent Care services received from a non-Plan Provider after the Member could reasonably be expected to travel to the nearest Plan Provider.
- D. Charges for services when the claim filing and notice procedures stated in Section 7 of the Certificate have not been followed by the Member.
- E. Charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless the Plan determine that the member could not reasonably be expected to return to the Service Area for such care.
- F. Except for covered ambulance services, travel, whether or not recommended by a Plan Provider.

LIMITATIONS AND EXCLUSIONS FOR MEDICAL DEVICES.

Benefits will not be provided for the purchase, rental or repair of the following:

- A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose e.g. elevators, hooyer/stair lifts, shower/bath bench.
- B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored e.g. chair or dresser.
- C. Exercise Equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body e.g. exercycle or other physical fitness equipment.
- D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home e.g. parallel bars.
- E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
- F. Eyeglasses, contact lenses, hearing aids, dental prostheses or appliances.
- G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.