

(n) PREVENTIVE AND ROUTINE CARE

Service	In-Network cost to Member
Preventive Care	0% Coinsurance

Prior Authorization is required for coverage of certain Covered Services. See the Utilization Management section for a list of these services. See the Pre-Service Claims subsection of the Claim and Appeal Procedures section for details on how to obtain Prior Authorization.

Covered Preventive Services are:

- (1) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- (2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved;
- (3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- (4) With respect to women, to the extent not described in 1 above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Any changes to the recommendations or guidelines referred to above will not be deemed Preventive Services until the first day of the Plan Year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Covered Services are provided for Preventive Care, Including:

- (a) Well-baby/child exams and routine periodic preventive exams, including routine gynecological exams
- (b) This includes required school and school athletic physicals and camp physicals
- (c) Preventive care services in conjunction with a routine periodic preventive exam as outlined below
- (d) Routine immunizations (including immunizations for foreign travel)
- (e) Routine hearing exams (limit of one exam per Member per Coverage Year)
- (f) Routine vision exams (limit of one exam per Member per Coverage Year)

Preventive Care Services	AGES											
<i>Covered preventive care services are limited to once per member per coverage year unless otherwise indicated.</i>												
All Members	> 5	≥ 11	≥ 12	≥ 18	≥ 19	≥ 20	≥ 45	≥ 50	≥ 55	≥ 60	≥ 75	> 80
Hepatitis C (HCV) screening for people at high risk for infection and one-time screening for people born between 1945 and 1965	X	X	X	X	X	X	X	X	X	X	X	X
Hepatitis B (HBV) screening for people at high risk for infection	X	X	X	X	X	X	X	X	X	X	X	X
Obesity screening and counseling	X	X	X	X	X	X	X	X	X	X	X	X
Chlamydia, gonorrhea and syphilis screening		X	X	X	X	X	X	X	X	X	X	X

High intensity behavioral counseling to prevent sexually transmitted diseases		X	X	X	X	X	X	X	X	X	X	X	X	X
Human immunodeficiency virus (HIV) screening		X	X	X	X	X	X	X	X	X	X	X	X	X
Depression screening			X	X	X	X	X	X	X	X	X	X	X	X
Diabetes screening				X	X	X	X	X	X	X	X	X	X	X
High blood pressure screening				X	X	X	X	X	X	X	X	X	X	X
Alcohol misuse screening and counseling					X	X	X	X	X	X	X	X	X	X
Healthy diet for hyperlipidemia/risk for diet related chronic disease counseling					X	X	X	X	X	X	X	X	X	X
Tobacco use behavioral interventions and FDA approved pharmacotherapy for adults who use tobacco					X	X	X	X	X	X	X	X	X	X
Lipid panel once every 5 years							X	X	X	X	X	X	X	X
Colorectal cancer screening options (one of the following): <ul style="list-style-type: none"> Fecal occult blood test (series of three) with flexible sigmoidoscopy every 5 years Barium enema and flexible sigmoidoscopy every 5 years CT Colonography every 5 years Colonoscopy once every 10 years 									X	X	X	X	X	X
Lung cancer screening with history of smoking											X	X	X	
Herpes zoster/shingles vaccine one time only												X	X	X
Intensive behavioral counseling interventions to promote a healthful diet and physical activity for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors				X	X	X	X	X	X	X	X	X	X	X
Children's Health	Birth	2	3	5	6	7	9	10	11	12	18	19	20	21
Expanded newborn screen (blood)	X													
Phenylketonuria (PKU) once at birth	X													
Evoked otoacoustic emissions (EOAE) once at birth	X													
Prophylactic eye medication for gonorrhea once at birth	X													
Congenital hypothyroidism screening – one time only between birth and 1 year	X													
Sickle cell disease screening – one time only between birth and 1 year	X													
Iron supplements – between 6-12 months*	X													
Autism screening	X	X												
Developmental screening – up to four screenings between birth and 36 months	X	X	X											
Psychosocial/Behavioral assessment – up to four assessments between birth and 36 months	X	X	X											
Pediatric vision screening	X	X	X	X										
Dental caries chemoprevention, oral fluoride*	X	X	X	X	X									
Lead level screening	X	X	X	X	X									
Human Immunodeficiency virus (HIV) screening if at increased risk for HIV	X	X	X	X	X	X	X	X						

Tuberculin skin testing (TB)	X	X	X	X	X	X	X	X	X	X	X			
Hepatitis C virus (HCV) screening for members at high risk	X	X	X	X	X	X	X	X	X	X	X			
Developmental surveillance	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin screening	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Metabolic/Hemoglobin	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lipid panel		X	X	X	X	X	X	X	X	X	X	X		
Alcohol and Drug use assessment									X	X	X	X	X	X
Men's Health						≥ 18	> 45	≥ 65	> 75	≥ 80				
Vasectomy sterilization procedure						X	X	X	X	X				
Aspirin to prevent Cardiovascular Disease (CVD)*							X	X	X					
Abdominal Aneurysm screening – one time only								X						
Women's Health						≥ 9	≥ 11	≥ 19	≥ 21	> 26	≥ 40	≥ 45	≥ 55	≥ 80
FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity*							X	X	X	X	X	X	X	X
Breast cancer chemoprevention counseling and treatment*								X	X	X	X	X	X	X
Counseling and testing related to BRCA with family history								X	X	X	X	X	X	X
Human papillomavirus (HPV) screening – once every 3 years beginning at age 30											X	X	X	
Papanicolaou smear (once every 3 years age 40-65)									X	X	X	X	X	
Mammogram											X	X	X	X
Breast cancer screening											X	X	X	X
Osteoporosis screening												X	X	X
Aspirin to prevent Cardiovascular Disease (CVD)*													X	
Preconception and Prenatal Care														
Folic acid supplements for members planning or capable of pregnancy*														
Bacteriuria screening for pregnant female – once per pregnancy														
Hepatitis B screening for pregnant female – once per pregnancy														
HIV screening for pregnant female														
Iron deficiency screening for pregnant female*														
RH Incompatibility screening for pregnant female – twice per pregnancy														
Syphilis screening for pregnant female														
Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for the rental or purchase of breastfeeding equipment which includes the following: <ul style="list-style-type: none"> • Non-hospital grade electric or manual breast pump, once per pregnancy, which includes breast pump supplies for nursing women. • Rental of a hospital grade pump requires a prescription and prior authorization after the 3rd month of rental. 														
Gestational diabetes screening for pregnant women after 24 weeks of gestation														
Aspirin to prevent preeclampsia after 12 weeks of gestation in women who are at high risk for preeclampsia *														
Immunizations – Frequency and specific age guidelines in accordance with the Advisory Committee on Immunization Practices									≤ 6	≥ 7	≥ 19			
Diphtheria, Tetanus, Pertussis (Tdap)*									X	X	X			
Hepatitis A*									X	X	X			

Hepatitis B*	X	X	X
Influenza*	X	X	X
Measles, Mumps, Rubella (MMR)*	X	X	X
Meningococcal*	X	X	X
Pneumococcal*	X	X	X
Inactivated Poliovirus (IPV)*	X	X	
Rotavirus*	X		
Haemophilus Influenzae Type B*	X		
Human papillomavirus (HPV)*		X	X
Varicella*		X	X

* Items noted with an asterisk may be covered under the outpatient prescription drug benefit.

If a diagnosis is indicated after a routine Preventive Care exam, the exam will be payable under the routine Preventive Care benefit; however, all Healthcare Services related to the diagnosis will be payable as any other Illness. Coverage for Members exhibiting an Illness or symptoms is included in the *Inpatient and Outpatient Hospital and Physician Services* subsection of this *Schedule of Benefits* section.

The following are not Covered Services under the Plan:

- Physicals for purposes of research, licensure, employment, or insurance
- The fitting, purchase, adjustment or repair of hearing aids
- Certain allergy testing: skin titration (Rinkle method), Cytotoxicity testing (Bryan's test), RAST testing, urine auto-injections, Provocative and Neutralization testing.
- Purchase or fitting of eyeglasses or other fabricated optical devices and purchase of contact lenses are not covered, except as specified in this section
- Radial keratotomy (RK)
- LASIK
- Photo refractive keratotomy (PRK)
- Other vision correction surgical procedures
- Orthoptics
- Orthoptic training
- Eye exercises, eye training and vision training
- Preventive Care services provided Out-of-Network
- Required school, athletic, and camp physicals
- Preventive Care services provided Out-of-Network, except well-baby/child exams as listed above