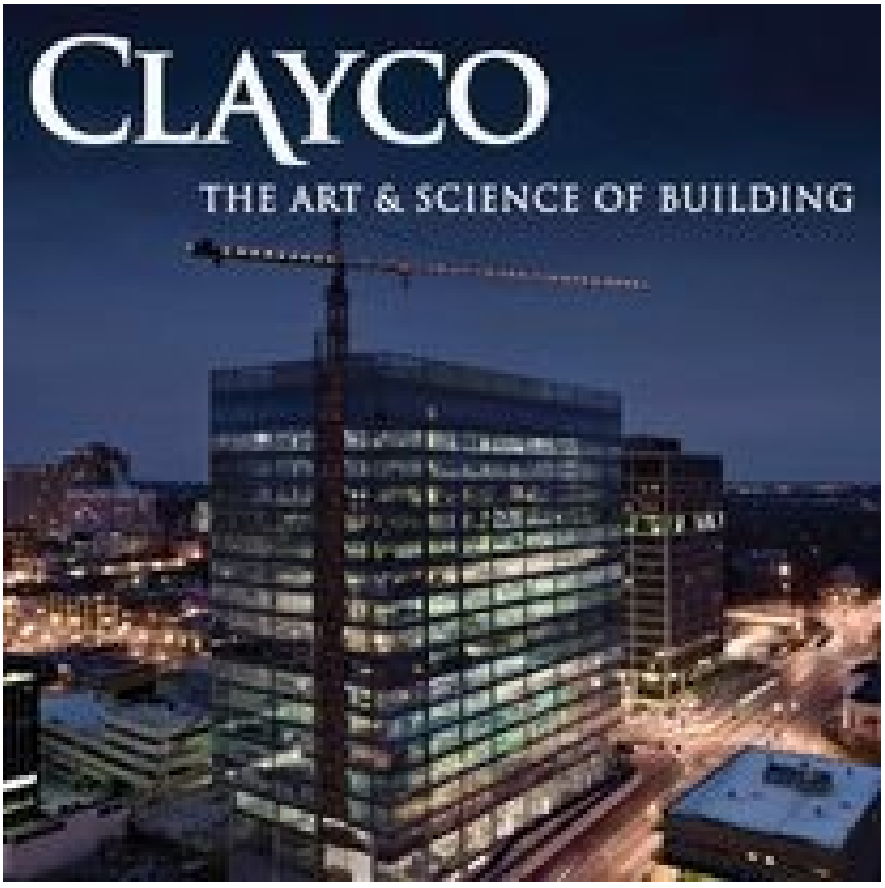

ClayCo, Inc.
ClayCo Employee Health Care Plan

Plan Document and Summary Plan Description
Effective 08/01/2018
Revised 08/01/2021

Mercy

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CLAYCO, INC.

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the CLAYCO, INC. Health Benefit Plan (the "Plan"). As a valued Employee of CLAYCO, INC., we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

CLAYCO, INC. is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third-Party Administrators to process claims and handle other duties for this self-funded Plan. The Third-Party Administrator for this Plan is Mercy Benefit Administrators, LLC. (hereinafter "MBA") for medical claims, and Express Scripts for pharmacy claims. The Third-Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.
The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore, it will be referred to as both the Summary Plan Description (“SPD”) and Plan document. It is being furnished to You in accordance with ERISA.

This document becomes effective on August 1, 2018.

PLAN INFORMATION

Plan Name	CLAYCO, INC. GROUP BENEFIT PLAN
Plan Subsidiaries	CONCRETE STRATEGIES, LLC FORUM STUDIO, INC. VENTANA DBS, LLC MU DAI, LLC LIFT TECHNOLOGIES, LLC
Name And Address Of Employer	CLAYCO, INC. 2199 INNERBELT BUSINESS CENTER DR ST LOUIS MO 63114
Name, Address And Phone Number Of Plan Administrator	CLAYCO, INC. 2199 INNERBELT BUSINESS CENTER DR ST LOUIS MO 63114 314-429-5100
Employer Identification Number Assigned By The IRS	43-1339079
Plan Number Assigned By The Plan	CC
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. MBA provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	CLAYCO, INC. 2199 INNERBELT BUSINESS CENTER DR ST LOUIS MO 63114 Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	August 1 through July 31

ERISA And Other Federal Compliance

It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third-Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third-Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year:		
• Per Person	$500	$2,000
• Per Family	$1,000	$4,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	90%	60%
Annual Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.***		
• Per Person	$2,000	$5,000
• Per Family	$4,000	$10,000
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	90%	90%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Cardiac Pulmonary Rehabilitation:		
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan After Deductible	90%	60%
Cardiac Rehabilitation Phase 1 & 2:		
• Maximum Visits Per Calendar Year	36 Visits	
• Paid By Plan After Deductible	90%	60%
Contraceptive Methods And Counseling Approved By The FDA:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Dental Services - Refer To The Covered Benefits Section For Details:		
• Paid By Plan After Deductible	90%	60%
Accident:		
• Maximum Benefit Per Accident Per Calendar Year	$3,000	
• Paid By Plan After Deductible	90%	60%

	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment: • Paid By Plan After Deductible	90%	60%
Emergency Services / Treatment: **Urgent Care:** • Co-pay Per Visit • Paid By Plan After Deductible	 $50 100% (Deductible Waived)	 Not Applicable 60%
Walk-in Retail Health Clinics: • Co-pay Per Visit • Paid By Plan After Deductible	 $25 100% (Deductible Waived)	 Not Applicable 60%
Emergency Room / Emergency Physicians: • Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) • Paid By Plan	 $150 100% (Deductible Waived)	 $150 100% (Deductible Waived)
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 90 Days 90%	 60%
Genetic Counseling and Testing: • Paid By Plan	 100% (Deductible Waived)	 100% (Deductible Waived)
Home Health Care Benefits: • Maximum Days Per Calendar Year Including Outpatient Private Duty Nursing • Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.***	 90 Days 90%	 60%
Hospice Care Benefits: • Paid By Plan After Deductible	 90%	 60%
Hospital Services: **Pre-Admission Testing:** • Paid By Plan After Deductible **Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:** • Paid By Plan After Deductible **Inpatient Physical Medicine / Rehabilitation Charges (Includes Day Rehabilitation Therapy Services On An Outpatient Basis):** • Maximum Days Per Calendar Year • Paid By Plan After Deductible **Outpatient Services / Outpatient Physician Charges:** • Paid By Plan After Deductible	 90% 90% 60 Days 90% 90%	 60% 60% 60% 60%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Imaging Charges:		
• Paid By Plan After Deductible	90%	60%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	90%	60%
Outpatient Surgery I Surgeon Charges:		
• Paid By Plan After Deductible	90%	60%
Infertility Treatment:		
• Maximum Benefit Per Lifetime	$15,000	
• Paid By Plan After Deductible	90%	60%
Manipulations:		
• Paid By Plan After Deductible	50%	No Benefit
Note: Medical Necessity Will Be Reviewed After 26 Visits.		
Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	90%	60%
Outpatient Birthing Centers:		
• Paid By Plan After Deductible	90%	60%
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:		
Inpatient Services I Physician Charges:		
• Paid By Plan After Deductible	90%	60%
Residential Treatment:		
• Paid By Plan After Deductible	90%	60%
Outpatient Or Partial Hospitalization Services And Physician Charges:		
• Paid By Plan After Deductible	90%	60%
Office Visit:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Physician Office Services:		
• Co-pay Per Visit - Primary Care Physician	$5	Not Applicable
• Co-pay Per Visit - Specialist	$20	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Office Surgery:		
• Paid By Plan After Deductible	90%	60%
Allergy Injections When Billed With An Office Visit:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Allergy Injections When Billed Without An Office Visit:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Allergy Testing		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Allergy Serum:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Private Duty Nursing: Included In Home Health Care Maximum		
• Paid By Plan After Deductible	90%	60%
Preventive I Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive I Routine Physical Exams At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Immunizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Mammograms And Breast Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Pelvic Exams And Pap Test:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine PSA Test And Prostate Exams: From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Screenings I Services At Appropriate Ages And Gender:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive I Routine Autism Screening: From Age 0 To 21		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Hearing Exams:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Eye Exam And Glaucoma Testing:		
• Co-pay Per Visit	$5	Not Applicable
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet And Nutrition:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive I Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
In Addition, The Following Preventive I Routine Services Are Covered For Women: **Gestational Diabetes** **Papillomavirus DNA Testing*** **Counseling For Sexually Transmitted Infections (Provided Annually) *** **Counseling For Human Immune-deficiency Virus (Provided Annually) *** **Contraceptive Methods And Counseling Approved By The FDA** **Breastfeeding Support, Supplies And Counseling** **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually) ***		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Note: These Services May Also Apply To Men		
Sterilizations:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Temporomandibular Joint Disorder Benefits:		
• Paid By Plan After Deductible	90%	60%
Therapy Services:		
Occupational Outpatient Hospital Only:		
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan After Deductible	90%	60%
Occupational Outpatient Office Therapy Only: Included In Maximum		
• Co-pay Per Visit	$20	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Physical Outpatient Hospital Only:		
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan After Deductible	90%	60%
Physical Outpatient Office Therapy Only: Included In Maximum		
• Co-pay Per Visit	$20	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Speech Outpatient Hospital Therapy:		
• Paid By Plan After Deductible	90%	60%
Speech Office Therapy:		
• Co-pay Per Visit	$20	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Note: Medical Necessity Will Be Reviewed After 25 Visits.		
Wigs, Toupees Or Hairpieces Related To Cancer Treatment:		
• Maximum Benefit Per Calendar Year	1 Wig, Toupee Or Hairpiece	
• Paid By Plan After In-Network Deductible	90%	90%
All Other Covered Expenses:		
• Paid By Plan After Deductible	90%	60%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) ALL	
Transplant Services At A Designated Transplant Facility:	
Transplant Services:	
• Paid By Plan	100% (Deductible Waived)
Travel And Housing:	
• Maximum Benefit Per Transplant	$10,000
• Paid By Plan	100% (Deductible Waived)
Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	
Unrelated Donor Searches For Bone Marrow I Stem Cell Transplants For Covered Transplant Procedure:	
• Maximum Benefit Per Transplant	$30,000 Per Transplant
• Paid By Plan	100% (Deductible Waived)

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next Plan Year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule or Negotiated Rate, as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs apply toward the in-network out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Out-of-network Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.

- Any charges above the limits specified elsewhere in this document.
- Out-of-network Co-pays and Participation amounts for Prescription products.
- Out-of-network individual and family Deductibles will not be used to meet the out-of-network out-of-pocket maximum.
- Any amounts over the Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any “fee forgiveness”, “not out-of-pocket” or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person’s claim may be denied, and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

WAITING PERIOD

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 30 calendar days of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased employees.
- An Independent Contractor as defined in this Plan.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a common-law marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- Your Domestic Partner, as long as he or she meets the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's or Domestic Partner's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).
  - A Child of a Domestic Partner.

- A Dependent does not include the following:

  - A foster Child;
  - A grandchild;
  - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and

- The Employee must still be covered under this Plan; and
- Must be dependent upon the Employee for more than 50 percent support and maintenance. The financial requirement does not apply to children who are enrolled in accordance with a QMCSO because of the Employee's divorce or separation decree; and
- Must be unmarried.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month coinciding with or following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will begin on that day; or

- If You apply after the completion of Your Waiting Period, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective August 1 following application during the annual open enrollment period. (Persons who apply under the Special Enrollment Provision are not considered Late Enrollees).

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or

- August 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 31 days following the date You acquire the Dependent; or

- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 31 days following the event; or

- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will be considered Late Enrollees. Covered Employees will be able to make a change in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be in the month of July. The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage shall be August 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 31 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage (Note: Eligible individuals must submit their enrollment forms prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided that the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends except in the event that the Employee dies, coverage for the Dependent can continue for three months following the death of the Employee, provided that the Dependent pays the applicable contribution when due; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent no longer qualifies as a Domestic Partner; or
- The end of the year in which Your Dependent Child attains the limiting age listed under the Eligibility section; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment Section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect;
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions or contact Your Human Resources or Personnel office.

COBRA CONTINUATION OF COVERAGE

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in the coverage thru the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally doesn't accept Late Enrollees.

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
• Your employment ends for any reason other than Yourgross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the plan as a Dependent	up to 36 months

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

UMR | COBRA Administration
PO BOX 1206
Wausau, WI 54402-1206
1-800-201-4904

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a loss of coverage) due to the original

- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- The date any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:

    - Employee's death.
    - Employee's divorce or legal separation.
    - Former Employee becomes enrolled in Medicare.
    - A Dependent Child no longer being a Dependent as defined in the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the 18-month period and within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in case of a newborn Child being added as a result of a HIPAA Special Enrollment right. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

CONTINUED COVERAGE FOR DOMESTIC PARTNERS

Domestic Partners do not qualify as Qualified Beneficiaries under federal COBRA law. Therefore, Domestic Partners do not have the right to elect COBRA independently and separately from the eligible Employee.

This Plan allows eligible Employees the right to choose which eligible Dependents (including Domestic Partners) will continue to be covered under a COBRA extension after a Qualifying Event. Only by selecting a COBRA extension that covers self and family can an eligible Employee extend COBRA coverage to a Domestic Partner.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
CLAYCO, INC.
2199 INNERBELT BUSINESS CENTER DR
ST LOUIS MO 63114
314-429-5100

The COBRA Administrator:
UMR
PO Box 1206
Wausau WI 54402-1206
1-800-201-4904

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan’s identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  Mercy Provider Network

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

  MultiPlan Shared Savings

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

Except as otherwise required under state or Federal regulations, the maximum amount the plan is obligated to pay for services provided by a non-primary Network provider will be the lesser of the provider’s billed charges for covered services and an amount determined by one or more of the following, which we may sometimes modify to maintain the reasonableness of the Allowed Amount:

- Using current publicly-available data reflecting fees typically reimbursed to providers for the same or similar professional services, adjusted for geographical differences where applicable.
- Using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences where applicable, plus a margin factor.
- Using amounts calculated based on what Medicare would reimburse for the services billed.
- Using the rates negotiated with the provider for all services provided under a non-primary network contract or claim-specific agreement.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

The program for Transplant Services at a Designated Transplant Facility is:

Optum Health

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. The following exceptions may apply:

- Covered Services provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist when services are provided at a Network facility or referred by an In-Network Physician, even if the provider is an Out-of-Network Provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the PPO benefit level by the prior Claims Administrator but which are not considered at the PPO benefit level by the current Claims Administrator may be paid at the applicable PPO benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post-acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call MBA within 30 days prior to the effective date or within 30 days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. 3D Mammograms, for claims initially processed on or after April 1, 2017, for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care Benefits.

2. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

3. **Allergy Treatment** including injections, testing and serum.

4. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically appropriate Hospital.

5. **Anesthetics and their Administration.**

6. **Aquatic Therapy.** (See Therapy Services below)

7. **Augmentation Communication Devices** and related instruction or therapy.

8. **Autism Spectrum Disorders (ASD) Treatment,** when Medical Necessity is met.
   (ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).
   ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy; or Applied Behavioral Analysis (ABA) Therapy. Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license (if ABA therapy, preferably a Board-Certified Behavior Analyst, BCBA).
   If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current Mercy guidelines, for example ABA treatment up to 25 hours per week for 3-6 months. Treatment plans specific to ABA Therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.
   Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).
   Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

9. **Blood Pressure Cuffs/Monitors**

10. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.

11. **Breast feeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

12. **Breast Reductions** if Medically Necessary.

13. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

14. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Services covered include:

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

15. **Cataract or Aphakia Surgery** as well as protective lenses following such procedure.

16. **Circumcision** and related expenses when care and treatment meet the definition of Medically Necessary. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

17. **Cleft Palate And Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

18. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives regardless of purpose. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

19. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an Optum Health facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

20. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.

21. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

22. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling.

23. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

24. **Durable Medical Equipment** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment is subject to review under the Care Management Provision of this SPD, if applicable.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
    - If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
      - due to the growth or development of a Dependent Child;
      - when necessary because of a change in the Covered Person’s physical condition; or
      - because of deterioration caused from normal wear and tear.

      The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
    - This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.

25. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

26. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must obtain prior authorization for services in advance. (Refer to the Care Management section of this SPD). The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

27. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

28. **Genetic Counseling** regardless of purpose.

29. **Genetic Testing** regardless of purpose.

30. **Hearing Services** include:

    - Exams, tests, services and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids provided to a newborn for initial amplification following a newborn hearing screening (including any necessary rescreening, audiological assessment and follow-up).
    - Implantable hearing devices.

31. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

32. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

33. **Hospital Services (Includes Inpatient Services, Surgical Centers And Inpatient Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate or the Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

34. Hospital Services (Outpatient).

35. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

36. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person. Coverage is provided for the diagnosis and treatment of infertility, including, but not limited to:
    a. In vitro fertilization.
    b. Uterine embryo lavage.
    c. Embryo transfer.
    d. Artificial insemination.
    e. Gamete intrafallopian tube transfer.
    f. Zygote intrafallopian tube transfer.
    g. Low tubal ovum transfer.

    The coverage provided above is subject to the following conditions:
    Benefits are provided for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer only if:
    a. The Covered person has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly medical infertility treatments for which coverage is available under the Policy, plan or contract; and
    b. The procedures are performed at facilities conforming to *The American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics or the *American Fertility Society* minimal standards for programs of in vitro fertilization.
    c. The patient must be the policy holder or the spouse of the policyholder and be considered an active, covered member on the policy.

37. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

38. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

39. **Maternity Benefits** for Covered Persons include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Medically Necessary diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwives.

40. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

41. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full fee allowance for the primary procedure and a percentage (%) for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

42. **Nursery And Newborn Expenses Including Circumcision**, are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

43. **Nutritional Counseling** if Medically Necessary.

44. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.

45. **Occupational Therapy.** (See Therapy Services below)

46. **Oral Surgery** includes:

- Reduction of fractures and dislocations of the jaw.

- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

47. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

48. **Oxygen And Its Administration.**

49. **Pharmacological Medical Case Management** (Medication management and lab charges).

50. **Physical Therapy.** (See Therapy Services below)

51. **Physician Services** for covered benefits.

52. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

53. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

54. **Preventive I Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in affect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- Well-woman Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-woman visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually-transmitted infections;
  - Counseling and screening for human immune-deficiency virus; and
  - Screening and counseling for interpersonal and domestic violence.

  Please visit the following links for additional information:

  https://www.healthcare.gov/preventive-care-benefits/
  https://www.healthcare.gov/preventive-care-children/
  https://www.healthcare.gov/preventive-care-women/

55. **Private Duty Nursing Services** when Outpatient care is required 24 hours a day, when provided through the Home Care Services benefit. This does not include Inpatient private duty nursing services.

56. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

57. **Qualifying Clinical Trials** as defined below, including routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health* (NIH), including the *National Cancer Institute* (NCI);
  - *Centers for Disease Control and Prevention* (CDC);
  - *Agency for Healthcare Research and Quality* (AHRQ);
  - *Centers for Medicare and Medicaid Services* (CMS);
  - A cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the Veteran's Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The *Department of Veterans Affairs*, the *Department of Defense,* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

58. Radiation Therapy and Chemotherapy.

59. Radiology and Interpretation Charges.

60. Reconstructive Surgery includes:

- Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore bodily function that has been impaired by a congenital Illness or anomaly, Accident, or from an infection or other disease of the involved part.

61. **Respiratory Therapy.** (See Therapy Services below)

62. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

63. **Sleep Disorders** if Medically Necessary.

64. **Sleep Studies.**

65. **Speech Therapy.** (See Therapy Services below)

66. **Sterilizations (Voluntary).**

67. **Substance Use Disorder Services** (Refer to Substance Use Disorder section of this SPD).

68. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

69. **Temporomandibular Joint Disorder (TMJ) Services** includes:

- Diagnostic services.
- Surgical treatment.
- Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

This does not cover orthodontic services.

70. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT), or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT), or other Qualified Provider, if applicable. by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
- **Speech therapy** by a Qualified speech therapist (ST), or other Qualified Provider, if applicable, including therapy for stuttering due to a neurological disorder.

71. **Tobacco Addiction:** Preventive / Routine benefits as required by applicable law and diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine.

72. **Transplant Services** (Refer to Transplant section of this SPD).

73. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

74. **Vision Care Services** (Refer to Vision Care section of this SPD).

75. **Walk-In Retail Health Clinics.** Charges associated with medical services provided at a Walk-In Retail Health Clinic.

76. **Wigs, Toupees, Hairpieces** for hair loss due to cancer treatment.

77. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services can include:

- Home visits instead of visits to the provider's office to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician, or other Qualified Provider, if applicable.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a Qualified therapist, or other Qualified Provider, if applicable.
- Medical supplies, drugs, or medication prescribed by a Physician and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer To Care Management section of this SPD for prior authorization requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisitional Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, which meets the criteria as determined by Care Management.
- Liver.

- Heart.
- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/Mileage.

- Lodging at or near the transplant facility including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or Unproven.
- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehension Cancer Network (NCCN) compendium.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION BENEFITS

Administered by Express Scripts

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to get prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

DEFINITIONS

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of pharmacies.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Pharmacy means a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Preferred Brand means a list of carefully selected medications that can assist in maintaining quality care for patients while helping to reduce the cost of Prescription Drug benefits under the Plan.

Prescription Drug means any drug that under Federal Drug Administration (FDA) or state law requires a written Prescription by a Physician. Drugs that are available without a Prescription are considered non-legend drugs.

Drugs and medicines prescribed by a licensed Physician and dispensed by a licensed pharmacist are covered by the Plan, except as otherwise provided by the Plan. Outpatient Prescription Drugs will be covered subject to the applicable Co-pay amounts and any limitations as stated in the Schedule of Benefits.

A covered drug must be approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or Physician.

Specialty Pharmacy Program means a program that has been determined by the Pharmacy Benefits Administrator to require reimbursement only through the approved specialty pharmacy vendor(s) at the "specialty pharmacy program" level of benefits as indicated.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. Newly approved drugs may be subject to review by the Plan Sponsor before being covered or may be excluded altogether. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed.

For a specific up-to-date list of covered and/or excluded Prescription Drugs, contact Express Scripts.

The following are **excluded** through the Prescription Drug program (this list is **not** all-inclusive):

- Applicable exclusions listed under General Exclusions section of this SPD.
- Prescription products if a prior authorization was necessary but not received or denied.
- Prescription products that are available over-the-counter.
- Prescription products that do not have Food and Drug Administration (FDA) approval for the purpose for which prescribed.
- All illegal drugs or supplies, even if prescribed by a duly licensed individual.
- Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation law, or any municipal, state or Federal program.

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.

This Plan does not coordinate Prescription benefits.

For any Prescription Drug questions, please contact Express Scripts at the following:

Express Scripts
800-451-6245

MENTAL HEALTH BENEFITS

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the maximum fee schedule or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. (Coverage does not include services provided in a community-based residential facility or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active Medically Necessary treatment forthe Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

    - Personality disorders; or
    - Sexual/gender identity disorders; or
    - Behavior and impulse control disorders;or
    - "V" codes (including marriage counseling).

- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders and chemical dependency. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. (Coverage does not include services provided in a community-based residential facility or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must include measurable goals and there must be continued progress toward functional behavior and termination of treatment. Continued coverage may be denied if positive response to treatment is not evident; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any; set out by the foreign government or regionally recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

CARE MANAGEMENT

Utilization Management

Utilization Management is the process of evaluating whether services, supplies or treatment is Medically Necessary and appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. Prior Authorization is not required to certify Medical Necessity for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is:

Integrated Healthcare Management
417-348-0783 or www.integratedplans.com

DEFINITIONS

The following terms are used for the purpose of the Care Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the Medical Necessity, effectiveness and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for anything listed in Attachment A.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD.

Medical Director Oversight. A Mercy Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case to case management for review. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points including the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within 30 calendar days of the receipt of request within Care Management, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Disease Management Program

The **Disease Management Program** identifies those individuals who have a certain chronic disease and would benefit from this program. Condition coaches telephonically work with Covered Persons to help them improve their chronic disease and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), diabetes, hypertension and depression – as a co-morbidity linked to another chronic condition we manage). Built within our system is a predictive modeling tool, Aerial Analytics and Clinical Intelligence Rules that takes up to two years' worth of medical and pharmacy claims data and then identifies those Covered Persons who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates are initially identified using a Health Condition Survey. The survey is a general screening questionnaire sent to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Once claims data is available, the predictive modeling tool is used to identify candidates for the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referral, other Care Management Programs, Nurse-On-Call referrals, the employer or the Covered Person's Physician.

In addition to the telephonic services, Mercy disease management also HealtheNotes. These targeted mailings are sent to Covered Persons' homes and avoid health care costs. Opportunities or gaps in care are identified through medical and or pharmacy data.

HealtheNotes provides useful, personalized information based on an individual Covered Person's health care utilization, including information on provider visits, prescriptions and health screenings.

The HealtheNotes is a vital educational tool in the Disease Management Program for managing a Covered Person's chronic condition(s). It assists in our efforts to significantly improve the quality of life for Covered Persons while simultaneously reducing overall healthcare costs.

Maternity Management

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of a long-term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. Covered Persons who enroll via the web receive a special edition pregnancy information guide. Mercy Care Management's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

Case Management

Case Management services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. Mercy Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. Mercy Care Management works directly with the patient, the patient's family members, the treating Physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

Nurse-On-Call

Nurse-On-Call service is a health information line that is available 24 hours per day, seven days a week that assists Covered Persons with medical-related questions and concerns. Nurse-On-Call gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- Where an individual is covered under one plan as a Dependent and another plan as an Employee, member or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- When an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the followingcircumstances:
  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longeractively employed by anemployer; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
  - You or Your covered spouse have retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in the Covered Medical Benefits section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.

2. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

3. **Acupuncture Treatment.**

4. **Alternative I Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

5. **Appointments Missed:** An appointment the Covered Person did not attend.

6. **Assistance With Activities of Daily Living.**

7. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.

8. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.

9. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

10. **Bereavement Counseling.**

11. **Biofeedback Services**.

12. **Blood:** Blood donor expenses.

13. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

14. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

15. **Claims** received later than 12 months from the date of service.

16. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

17. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

18. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

19. **Custodial Care** as defined in the Glossary of Terms of this SPD.

20. **Dental Services:**

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

21. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy that are not Medically Necessary and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

22. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

23. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

24. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

25. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.

26. **Excess Charges:** Charges or the portion thereof which are in excess of the Negotiated Rate or fee schedule.

27. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. This does not include Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

28. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

29. **Family Planning:** Consultation for family planning.

30. **Financial Counseling**.

31. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

32. **Foot Care (Podiatry):** Routine foot care.

33. **Genetic Testing** unless covered elsewhere in this SPD.

34. **Growth Hormones.**

35. **Home Births** and associated costs.

36. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

37. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

38. **Infertility Treatment:**

- Fertility tests.
- Surgical reversal of a sterilized state which was a result of a previous surgery.
- Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
- Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
- Embryo transfer.
- Freezing or storage of embryo, eggs, or semen.
- Genetic testing.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.

39. **Inpatient Private Duty Nursing Services**

40. **Lamaze Classes** or other childbirth classes.

41. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

42. **Liposuction** regardless of purpose.

43. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

44. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

45. **Marriage Counseling.**

46. **Massage Therapy.**

47. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

48. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

49. **Nocturnal Enuresis Alarm** (Bed wetting).

50. **Non-Custom-Molded Shoe Inserts.**

51. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

52. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

53. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.

54. **Nutrition Counseling** unless covered elsewhere in this SPD.

55. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.

56. Orthognathic, Prognathic and Maxillofacial Surgery.

57. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere inthis SPD.

58. Palliative Foot Care.

59. **Panniculectomy I Abdominoplasty** unless determined by the Plan to be Medically Necessary.

60. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

61. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.

62. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

63. **Return to Work I School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

64. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

65. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

66. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

67. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.

68. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

69. **Services** that should legally be provided by a school.

70. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

71. **Sex Therapy.**

72. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

73. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

74. **Standby Surgeon Charges.**

75. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

76. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

77. **Telemedicine - Telephone or Internet Consultations.**

78. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

79. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

80. **Vision Care** unless covered elsewhere in this SPD.

81. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

82. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

83. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

84. **Weight Control:** Treatment, services or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

85. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

86. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker’s Compensation, U.S. Longshoremen and Harbor Worker’s or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

87. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Care Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third-Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When MBA receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied, and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, MBA will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule or a Negotiated Rate for certain services.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, MBA will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual and Customary (U&C) is the amount that, except as otherwise required under state or Federal regulations, the maximum amount the plan is obligated to pay for services provided by a non-primary PPO provider will be the lesser of the provider's billed charges for covered services and an amount determined by one or more of the following, which we may sometimes modify to maintain the reasonableness of the Allowed Amount:
•Using current publicly available data reflecting fees typically reimbursed to providers for the same or similar professional services, adjusted for geographical differences where applicable.
•Using current publicly available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences where applicable, plus a margin factor.
•Using amounts calculated based on what Medicare would reimburse for the services billed.
•Using the rates negotiated with the provider for all services provided under a non-primary network contract or claim-specific agreement.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

MBA will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.

- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to MBA for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal seven days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

This Plan contracts with various companies to administer different parts of this Plan. Covered Persons who want to appeal a decision or a claim determination that one of these companies made, should send appeals directly to the company that made the decision being appealed. The names and addresses of the companies that the Plan contracts include:

Appeals should be sent within the prescribed time period as stated above to the following address(es):

Send Post-Service Claim Medical appeals to:
MBA
CLAIMS APPEAL UNIT
PO BOX 14230
SPRINGFIELD MO 65807

Send Pre-Service Claim Medical appeals to:
MERCY CARE MANAGEMEN
4520 S NA IONAL 2ND FL
SPRINGFIELD MO 65810

EXPRESS SCRIPTS 1
EXPRESSWAY
S LOUIS MO 63121

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional date of the response.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination You may choose to participate in the external review program. This program only applies if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determination related toto whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- As Otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if MBA or Your employer fail to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor MBA or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

MBA
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 14230
SPRINGFIELD MO 65807

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, when applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

All requests for an independent review must be made within four (4) months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by MBA and has no material affiliation or interest with MBA or Your employer. MBA will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by MBA and/or Your employer in making a decision on the case; and
- all other information or evidence that You or Your Physician has already submitted to MBA or Your employer.

If there is any information or evidence You or Your Physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and MBA will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and MBA and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details. **No such action may be filed against the Plan after three years from the date the Plan gives the Covered Person a final determination on their appeal.**

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person, or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by ERISA.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor Shall Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict, and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Assistant Controller, Benefits Coordinator

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons shall have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator’s principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, contact the Plan Administrator. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person’s rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third-Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or for treating condition of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a step Child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee or Spouse's or Domestic Partner's Legal Guardianship; a Child of a Domestic Partner or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, Your Domestic Partner, mother, father, grandmother, grandfather, stepparents, step grandparents, siblings, step siblings, half siblings, Children, Your Domestic Partner's Children, Step Children and grandchildren.

Co-pay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, which is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Domestic Partner means: An unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, is jointly responsible for the other's welfare and financial obligations, is at least 18 years of age, is not related by blood, maintains the same residence and is not married or legally separated from anyone else. A Domestic Partner certification is required to be completed and filed with the Plan at the time enrollment of the Domestic Partner is requested.

For Your Domestic Partner to qualify as a Dependent, You and Your partner must complete an affidavit declaring that You and Your partner:

- Are in a relationship of mutual support, caring and commitment and are responsible for each other's welfare;
- Have maintained this relationship for the past six months and intend to do so indefinitely;
- Have shared a primary residence for the past six months and intend to do so indefinitely;
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally, is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the first day of the Waiting Period, whichever is earlier.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the Enrollment Date is the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the applicable regulations.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

Experimental, Investigational or **Unproven** means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person’s attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient’s expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term “Illness” when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received, or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: Basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual’s achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship-Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual’s property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary I Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with Generally Accepted Standards of Medical Practice; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury, disease or symptoms

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Mercy Care Management (MCM) develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by MCM and revised from time to time), are available to Covered Persons, Physicians and other health care professionals by calling MBA at the telephone number on Your ID card.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefits means any medical benefit that is not an Essential Health Benefit. Please refer to the Essential Health Benefits definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: ~~a~~ doctor of medicine (MD), doctor of medical dentistry including an oral surgeon (DMD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of chiropractic (DC), doctor of optometry (OPT). Subject to the limitations below, the term 'Physician' shall also include the following practitioner types: physician's assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means CLAYCO, INC. Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the medication or supply prescribed.

Preventive I Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders. Generally, they provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians that are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder treatment providers.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well-being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Disease – Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

    - Personality disorders; or
    - Sexual/gender identity disorders; or
    - Behavior and impulse control disorders; or
    - "V" codes.

Urgent Care is the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have an Injury or Illness that requires immediate care but is not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Waiting Period means the period of time that must pass before coverage can become effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such clinics must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You, Your means the Employee.

Standard Prior Authorization List

PRIOR AUTHORIZATION: Prior Authorization is required for certain services and procedures. To request and receive prior-authorization for a required service or procedure, you or your Provider *must* contact Mercy Benefit Administration Utilization at 1-417-348-0783. It is Your responsibility to obtain Prior Authorization. *Failure to obtain Prior Authorization may result in denial of Plan benefits even if Medically Necessary.* Generally, Out-of-Network Services and Providers are not covered. If You or Your Provider obtain Prior Authorization for Medically necessary out-of-network services that are not available in-network, those benefits are subject to the Plan's usual, customary and reasonable limits. Balance Billing may apply, and You will be solely responsible for any excess amount charged by the out-of-network provider.

Brief Summary:

All Inpatients

Behavioral Health

Substance Use Disorder

Skilled Nursing (SNF)

Long-term Acute Care (LTACH)

Rehabilitation admissions

Emergency admissions (require plan notification within 24 hours)

Maternity admission requires prior authorization under the following circumstances:

- Newborn stays beyond mother's discharge
- Mother stays beyond 48 hours for vaginal delivery or 72 hours for C-section

Hospice and Palliative Care

Home Health Care including

- Skilled nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Durable Medical Equipment (DME)

- Any single line item over $1,000 (purchase price or cumulative rental not including oxygen and oxygen equipment).
- PAP units (not supplies) E0601, E0471
- Home ventilators (invasive and non-invasive)
- Oscillatory devices for airway clearance including high frequency chest compressions and intrapulmonary percussive ventilation
- Nutritional support (enteral and parenteral feeding)
- TENS units (not supplies)
- Bone growth stimulators
- Neuromuscular stimulators
- Functional Electrical Stimulation (FES)
- Threshold Electrical Stimulation (TES)
- Hospital beds, including, but not limited to: rocking beds, cribs, mattresses

- Wheelchairs and accessories
- Insulin pumps (not supplies), external continuous insulin infusion pump
- Continuous glucose monitors
- Wearable Cardiac Defibrillator
- Standing frames
- Pneumatic compression devices
- Cooling devices and combined cooling/heating devices
- Augmentative and Alternative Communication (AAC) Devices, Speech Generating Devices
- All custom-made items
- Orthotics over $1,000, all foot orthotics, diabetic shoes and any custom orthotic
- Prosthetics including but not limited to Cochlear implants and auditory brainstem implants

Accidental dental services

Ambulances (air and water)

Ambulance transfers (non-emergent)

Clinical Trials

Genetic testing (list is not all inclusive)

Gene Therapy

Phototherapy

All " T" codes (Category III Codes)

All non-specific codes (e.g. "99" codes)

Bone and cartilage grafts excluding middle ear and nasal surgery

Behavioral Health /Substance Use Disorder

- All facility-based care
- Inpatient admissions
- Intensive outpatient therapy
- Partial hospitalization
- Residential care
- ABA (Applied Behavioral Analysis)
- Electric Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation
- Intensive in-home behavioral health services
- Psychometric testing
- Psychological testing
- Neuropsychological testing
- Psychoanalysis
- Narcosynthesis

Psychological testing by a computer with interpretation

Mental health services by a non-behavioral health practitioner

Behavioral health day treatment

Therapeutic behavioral services

Urine Drug Testing or Chronic Pain or SUD

Esketamine (Spravato) Therapy

Medical Benefit Specialty Drugs (Not a comprehensive list; see detailed prior authorization list under separate attachment.)

Anti-inflammatory/Anti-rheumatic

Biologic agents

Botulinum Toxin

Collagenases

Eye Disorders

Gene Therapy/CAR-T

Hemophilia

Hereditary Angioedema

Hormonal Therapy/Androgens

Hyaluronidases/Joint Injections

Immune globulin

Infertility

Iron Replacement (injectable)

Metabolic enzymes

Monoclonal antibodies

Multiple Sclerosis

Oncology/Anti-cancer

Osteoporosis

Respiratory (injectable drugs)

Selected Antiinfectives

Selected Vaccines/Immunizations

Prior Authorization Guide

CPT code	Description
00170	Anesthesia for intraoral procedures, including biopsy
01999	Unlisted anesthesia procedure(s)
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
15271	Application of skin substitute graft to trunk, arms, leg's, total wound surface area up to 100 sq. cm; first 25 sq. cm or less
15272	Application of skin substitute graft to trunk, arms, leg's, total wound surface area up to 100 sq. cm; each additional 25 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq. cm; first 25 sq. cm or less wound surface area
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq. cm; each additional 25 sq. cm wound surface area, or part
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq. cm; first 100 sq. cm wound surface area, or 1%
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq. cm; each additional 100 sq. cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or leg's; 50 cc or less
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or leg's; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands,
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk)
15780	Dermabrasion; total face
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy

15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg.
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
15841	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
15842	Graft for facial nerve paralysis; free muscle flap by microsurgical technique
15845	Graft for facial nerve paralysis; regional muscle transfer
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
15999	Unlisted procedure, excision pressure ulcer
17106	Destruction of cutaneous vascular proliferative lesions
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq. cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq. cm
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma
19300	Mastectomy for gynecomastia
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364	Breast reconstruction with free flap
19366	Breast reconstruction with other technique
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
19499	Unlisted procedure, breast
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
20704	Manual preparation and insertion of drug-delivery device(s), intra-articular
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20975	Electrical stimulation to aid bone healing; invasive (operative
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

20982	Ablation therapy for reduction or eradication of 1 or more bone tumors
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less
20999	Unlisted Procedure Muscskeletal System General
21010	Arthrotomy, temporomandibular joint
21050	Condylectomy temporomandibular joint SPX
21060	Meniscectomy PRTL/COMPL temporomandibular JT SPX
21070	Coronoidectomy separate procedure
21077	Impression & Preparation Orbital Prosthesis
21079	Impression & Preparation Interim Obturator Prost
21083	Impression & Preparation Palatal Lift Prosthesis
21084	Impression & Preparation Speech Aid Prosthesis
21085	Impression & Preparation Oral Surgical Splint
21086	Impression & Preparation Auricular Prosthesis
21087	Impression & Preparation Nasal Prosthesis
21088	Impression & Preparation Facial Prosthesis
21089	Unlisted Maxillofacial Prosthetic Procedure
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome),
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)

21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas
21215	Graft, bone; mandible (includes obtaining graft
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242	Arthroplasty, temporomandibular joint, with allograft
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial
21248	Reconstruction of mandible or maxilla, endosteal implant
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21270	Malar augmentation, prosthetic material
21275	Secondary revision of orbitocraniofacial reconstruction
21299	Unlisted craniofacial and maxillofacial procedure
21499	Unlisted musculoskeletal procedure, head
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with
21899	Unlisted procedure, neck or thorax
22100	Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single
22101	Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single
22102	Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single
22103	Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single
22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single
22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single
22114	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single
22116	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral
22505	Manipulation of spine requiring anesthesia, any region

22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection,
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment;
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior
22830	Exploration of spinal fusion
22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)
22841	Internal spinal fixation by wiring of spinous processes
22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6
22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12
22844	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or
22845	Anterior instrumentation; 2 to 3 vertebral segments
22846	Anterior instrumentation; 4 to 7 vertebral segments
22847	Anterior instrumentation; 8 or more vertebral segments

22848	Pelvic fixation
22849	Reinsertion of spinal fixation device
22850	Removal of posterior nonsegmental instrumentation
22852	Removal of posterior segmental instrumentation
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody
22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial
22855	Removal of anterior instrumentation
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection);
22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level
22899	Unlisted procedure, spine
22999	Unlisted procedure, abdomen, musculoskeletal system
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component
23929	Unlisted procedure, shoulder
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component
24999	Unlisted procedure, humerus or elbow
25999	Unlisted procedure, forearm or wrist
26530	Arthroplasty, metacarpophalangeal joint; each joint
26531	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint
26535	Arthroplasty, interphalangeal joint; each joint
26536	Arthroplasty, interphalangeal joint; with prosthetic implant, each joint
26550	Pollicization of a digit
26989	Unlisted procedure, hands or fingers
27080	Coccygectomy, primary
27091	Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft
27140	Osteotomy and transfer of greater trochanter of femur (separate procedure)
27146	Osteotomy, iliac, acetabular or innominate bone;
27147	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip
27151	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy
27156	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip
27158	Osteotomy, pelvis, bilateral (e.g., congenital malformation)
27161	Osteotomy, femoral neck (separate procedure)

27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur
27187	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed
27299	Unlisted procedure, pelvis or hip joint
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft)
27445	Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total
27486	Revision of total knee arthroplasty, with or without allograft; 1 component
27487	Revision of total knee arthroplasty, with or without allograft; 1 component
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer
27599	Unlisted procedure, femur or knee
27702	Arthroplasty, ankle; with implant (total ankle)
27703	Arthroplasty, ankle; revision, total ankle
27886	Amputation, leg., through tibia and fibula; re-amputation - INPATIENT ONLY LIST
27899	Unlisted procedure, leg or ankle
28345	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia
28899	Unlisted procedure, foot or toes
29799	Unlisted procedure, casting or strapping
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft)
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)
29999	Unlisted procedure, arthroscopy
30120	Excision or surgical planing of skin of nose for rhinophyma
30160	Rhinectomy; total
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision
30435	Rhinoplasty, secondary; intermediate revision
30450	Rhinoplasty, secondary; major revision
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30999	Unlisted procedure, nose
31299	Unlisted procedure, accessory sinuses
31574	Laryngoscopy, flexible; with injection(s) for augmentation (e.g., percutaneous, transoral), unilateral
31599	Unlisted procedure, larynx
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance,
31899	Unlisted procedure, trachea, bronchi
32491	Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when
32664	Thoracoscopy, surgical; with thoracic sympathectomy
32672	Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed
32994	Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous,

32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency.
32999	Unlisted procedure, lungs and pleura
33254	Operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure)
33255	Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); without cardiopulmonary bypass
33256	Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); with cardiopulmonary bypass
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (e.g., modified maze procedure) (List separately in addition to code for primary procedure)
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (e.g., maze procedure), without cardiopulmonary bypass
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (e.g., maze procedure), with cardiopulmonary bypass (
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure),
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure), without
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming
33286	Removal, subcutaneous cardiac rhythm monitor
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (e.g., median
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site,
33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (e.g., ventricular remodeling,
33647	Repair of atrial septal defect and ventricular septal defect, with direct or patch closure - INPATIENT ONLY LIST
33726	Repair of pulmonary venous stenosis - INPATIENT ONLY LIST
33730	Complete repair of anomalous pulmonary venous return (supracardiac, intracardiac, or infracardiac types
33782	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair
33783	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair
33975	Insertion of ventricular assist device; extracorporeal, single ventricle
33976	Insertion of ventricular assist device; extracorporeal, biventricular
33977	Removal of ventricular assist device; extracorporeal, single ventricle
33978	Removal of ventricular assist device; extracorporeal, biventricular
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle
33981	Replacement of extracorporeal ventricular assist device, single or biventricular,
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary
33990	Insertion of ventricular assist device
33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial
33999	Unlisted procedure, cardiac surgery
36299	Unlisted procedure, vascular injection
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (e.g., great
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (e.g., great saphenous
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk
36470	Injection of sclerosing solution; single vein
36471	Injection of sclerosing solution; multiple veins, same leg
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring,

36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity,
36475	Endovenous ablation therapy of incompetent vein, extremity
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring,
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g.,
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g.,
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention;
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and
37501	Unlisted vascular endoscopy procedure
37799	Unlisted procedure, vascular surgery stab phel <10
38129	Unlisted laparoscopy procedure, spleen
38243	Hematopoietic progenitor cell (HPC); HPC boost
38589	Unlisted laparoscopy procedure, lymphatic system
38999	Unlisted procedure, hemic or lymphatic system
39499	Unlisted procedure, mediastinum
39599	Unlisted procedure, diaphragm
40799	Unlisted procedure, lips
40840	Vestibuloplasty; anterior
40842	Vestibuloplasty; posterior, unilateral
40843	Vestibuloplasty; posterior, bilateral
40844	Vestibuloplasty; entire arch
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
40899	Unlisted procedure, vestibule of mouth
41130	Glossectomy; hemiglossectomy
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck
41512	Tongue base suspension, permanent suture technique
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites
41599	Unlisted procedure, tongue, floor of mouth
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806	Removal of embedded foreign body from dentoalveolar structures; bone
41820	Gingivectomy, excision gingiva, each quadrant
41821	Operculectomy, excision pericoronal tissues
41822	Excision of fibrous tuberosities, dentoalveolar structures
41823	Excision of osseous tuberosities, dentoalveolar structures
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair
41827	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair
41828	Excision of hyperplastic alveolar mucosa, each quadrant
41830	Alveolectomy, including curettage of osteitis or sequestrectomy
41850	Destruction of lesion (except excision), dentoalveolar structures
41870	Periodontal mucosal grafting
41872	Gingivoplasty, each quadrant
41874	Alveoloplasty, each quadrant
41899	Unlisted procedure, dentoalveolar structures

42140	Uvulectomy, excision of uvula
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)
42299	Unlisted procedure, palate, uvula
42699	Unlisted procedure, salivary glands or ducts
42999	Unlisted procedure, pharynx, adenoids, or tonsils
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy
43280	Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures)
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of
43283	Laparoscopy, surgical, esophageal lengthening procedure (e.g., Collis gastroplasty or wedge gastroplasty) (List
43289	Unlisted laparoscopy procedure, esophagus
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of
43499	Unlisted procedure, esophagus
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43999	Unlisted procedure, stomach
44238	Unlisted laparoscopy procedure, intestine (except rectum)
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen
44799	Unlisted procedure, small intestine
44899	Unlisted procedure, Meckel's diverticulum and the mesentery
44979	Unlisted laparoscopy procedure, appendix
45399	Unlisted procedure, colon
45499	Unlisted laparoscopy procedure, rectum
45999	Unlisted procedure rectum
46999	Unlisted procedure anus
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical
47379	Unlisted laparoscopic procedure, liver
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency
47381	Ablation, open, of 1 or more liver tumor(s); cryosurgical
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
47399	Unlisted procedure liver
47579	Unlisted laparoscopy procedure biliary tract
47999	Unlisted procedure, biliary tract

48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy - INPATIENT ONLY LIST
48999	Unlisted procedure pancreas
49185	Sclerotherapy of a fluid collection (e.g., lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (e.g., ultrasound, fluoroscopy) and radiological supervision
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure) - INPATIENT ONLY LIST
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
49999	Unlisted procedure, abdomen, peritoneum and omentum
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring,
50549	Unlisted laparoscopy procedure, renal
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy
50949	Unlisted laparoscopy procedure, ureter
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
51999	Unlisted laparoscopy procedure, bladder
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent
52450	Transurethral incision of prostate
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete
52648	Laser vaporization of prostate
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary
53899	Unlisted procedure, urinary system
54125	Amputation of penis; complete;
54300	Plastic operation of penis for straightening of chordee (e.g., hypospadias), with or without mobilization of urethra
54360	Plastic operation on penis to correct angulation
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54440	Plastic operation of penis for injury
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy;
54699	Unlisted laparoscopy procedure, testis
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55400	Vasovasostomy, vasovasorrhaphy
55559	Unlisted laparoscopy procedure, spermatic cord
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
55970	Intersex surgery; male to female;
55980	Intersex surgery; female to male;

56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56633	Vulvectomy, radical, complete;
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical
57106	Vaginectomy, partial removal of vaginal wall
57110	Vaginectomy, complete removal of vaginal wall;
57291	Construction of artificial vagina; without graft;
57292	Construction of artificial vagina; with graft;
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57305	Closure of rectovaginal fistula; abdominal approach - INPATIENT ONLY LIST
57311	Closure of urethrovaginal fistula; with bulbocavernosus transplant
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure) - INPATIENT ONLY PROCEDURE
58578	Unlisted laparoscopy procedure, uterus
58579	Unlisted hysteroscopy procedure, uterus
58679	Unlisted laparoscopy procedure, oviduct, ovary
58970	Follicle puncture for oocyte retrieval, any method
58974	Embryo transfer, intrauterine
58999	Unlisted procedure, female genital system (nonobstetrical)
59525	Subtotal or total hysterectomy after cesarean delivery
59897	Unlisted fetal invasive procedure, including ultrasound guidance
59898	Unlisted laparoscopy procedure, maternity care and delivery
59899	Unlisted procedure, maternity care and delivery
60659	Unlisted laparoscopy procedure, endocrine system
60699	Unlisted procedure, endocrine system
61630	Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous
61635	Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon
61640	Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel
61641	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family
61642	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple
61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion
61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex
61800	Application of stereotactic headframe for stereotactic radiosurgery
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in
61870	Craniectomy for implantation of neurostimulator electrodes, cerebellar, cortical
61880	Revision or removal of intracranial neurostimulator electrodes
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with
61888	Revision or removal of cranial neurostimulator pulse generator or receiver
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar

63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; thoracic
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; cervical
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; thoracic
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; thoracic
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment,
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g., wire,
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc),
63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical,
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic,
63078	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment

63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
63087	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment
63088	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List
63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment
63091	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic, single
63102	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); lumbar, single
63103	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic or lumbar,
63170	Laminectomy with myelotomy (e.g., Bischof or DREZ type), cervical, thoracic, or thoracolumbar
63172	Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space
63173	Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space
63180	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; 1 or 2 segments
63182	Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than 2 segments
63185	Laminectomy with rhizotomy; 1 or 2 segments
63190	Laminectomy with rhizotomy; more than 2 segments
63191	Laminectomy with section of spinal accessory nerve
63194	Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; cervical
63195	Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; thoracic
63196	Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; cervical
63197	Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; thoracic
63198	Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; cervical
63199	Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; thoracic
63200	Laminectomy, with release of tethered spinal cord, lumbar
63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical
63251	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic
63252	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural;
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63273	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral
63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic
63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
63278	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral
63280	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63281	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic
63282	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar
63283	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacral
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63286	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic
63287	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level
63295	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in
63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment;

63301	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment;
63302	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment;
63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment;
63305	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment;
63306	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment;
63307	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63308	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
64405	Injection, anesthetic agent; greater occipital nerve
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming
64568	Incision for implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator
64569	Revision or replacement of cranial nerve (e.g., vagus nerve) neurostimulator electrode array, including connection to
64570	Removal of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580	Incision for implantation of neurostimulator electrode array; neuromuscular
64581	Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (e.g., for blepharospasm, hemifacial
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves,
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (e.g., for cervical dystonia,
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed
64632	Destruction by neurolytic agent; plantar common digital nerve
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or
64640	Destruction by neurolytic agent; other peripheral nerve or branch
64642	Chemodenervation of one extremity; 1-4 muscle(s)
64643	Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for
64644	Chemodenervation of one extremity; 5 or more muscles
64645	Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code
64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)
64647	Chemodenervation of trunk muscle(s); 6 or more muscles
64716	Neuroplasty and/or transposition; cranial nerve
64732	Transection or avulsion of; supraorbital nerve
64734	Transection or avulsion of; infraorbital nerve
64736	Transection or avulsion of; mental nerve
64738	Transection or avulsion of; inferior alveolar nerve by osteotomy
64740	Transection or avulsion of; lingual nerve
64742	Transection or avulsion of; facial nerve, differential or complete
64771	Transection or avulsion of other cranial nerve, extradural
64772	Transection or avulsion of other spinal nerve, extradural

64787	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)
64804	Sympathectomy, cervicothoracic
64864	Suture of facial nerve; extracranial
64865	Suture of facial nerve; infratemporal, with or without grafting
64866	Anastomosis; facial-spinal accessory
64868	Anastomosis; facial-hypoglossal
64910	Nerve repair; with synthetic conduit or vein allograft (e.g., nerve tube), each nerve
64911	Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve
64999	Unlisted procedure, nervous system
65760	Keratomileusis
65771	Radial keratotomy
66999	Unlisted procedure, anterior segment of eye
67220	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), 1 or more
67221	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes
67225	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary procedure)
67299	Unlisted procedure, posterior segment
67345	Chemodenervation of extraocular muscle
67399	Unlisted procedure, extraocular muscle
67599	Unlisted procedure, orbit
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)
67950	Canthoplasty (reconstruction of canthus)
67999	Unlisted procedure, eyelids
68399	Unlisted procedure, eyelids
68700	Plastic repair of canaliculi
68899	Unlisted procedure, lacrimal system
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
69310	Reconstruction of external auditory canal (meatoplasty)
69320	Reconstruction external auditory canal for congenital atresia, single stage
69399	Unlisted procedure, external ear
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69799	Unlisted procedure, middle ear
69930	Cochlear device implantation, with or without mastoidectomy
69949	Unlisted procedure, inner ear
69955	Total facial nerve decompression and/or repair (may include graft
69979	Unlisted procedure, temporal bone, middle fossa approach
70332	Temporomandibular joint arthrography, radiological supervision and interpretation

70554	Magnetic resonance imaging, brain, functional MRI;
70555	Magnetic resonance imaging, brain, functional MRI;
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s)
74263	Computed tomographic (CT) colonography, screening, including image postprocessing
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing,
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material,
76390	Magnetic resonance spectroscopy
76496	Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)
76497	Unlisted computed tomography procedure (e.g., diagnostic, interventional)
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
76499	Unlisted diagnostic radiographic procedure
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
76999	Unlisted ultrasound procedure (e.g., diagnostic, interventional)
77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine
77080	Dual-energy X-ray absorptiometry (DXA), bone density study
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g.,
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s)
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s)
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance,
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
77499	Unlisted procedure, therapeutic radiology treatment management
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex
77799	Unlisted procedure, clinical brachytherapy
78099	Unlisted endocrine procedure, diagnostic nuclear medicine
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
78599	Unlisted respiratory procedure, diagnostic nuclear medicine
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78699	Unlisted nervous system procedure, diagnostic nuclear medicine
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine

78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh
78813	Positron emission tomography (PET) imaging; whole body
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction
78999	Unlisted genitourinary procedure, diagnostic nuclear medicine
79999	Radiopharmaceutical therapy, unlisted procedure
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS,
81099	Unlisted urinalysis procedure
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (i.e., detection of large gene
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81165	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81167	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (e.g., acquired imatinib tyrosine kinase inhibitor resistance),
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (e.g., expanded size and methylation status
81173	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene
81174	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full sequence
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (e.g., exon 12)
81177	ATN1 (atrophin 1) (e.g., dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (e.g.,
81178	ATXN1 (ataxin 1) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81179	ATXN2 (ataxin 2) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81180	ATXN3 (ataxin 3) (e.g., spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal
81181	ATXN7 (ataxin 7) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect
81183	ATXN10 (ataxin 10) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; evaluation to
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; full gene
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; known familial
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (e.g., myotonic dystrophy type 2) gene analysis, evaluation to
81188	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (e.g., expanded)
81189	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; full gene sequence
81190	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; known familial variant(s)
81200	ASPA (aspartoacylase) (e.g., Canavan disease) gene analysis, common variants (e.g., E285A, Y231X)
81201	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene
81202	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known
81203	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis;
81204	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (e.g., expanded size or methylation status)

81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (e.g., maple syrup urine disease) gene analysis,
81209	BLM (Bloom syndrome, RecQ helicase-like) (e.g., Bloom syndrome) gene analysis, 2281del6ins7 variant
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (e.g., colon cancer, melanoma), gene analysis, V600 variant(s)
81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants
81215	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
81216	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81217	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (e.g., acute myeloid leukemia), gene analysis, full gene
81219	CALR (calreticulin) (e.g., myeloproliferative disorders), gene analysis, common variants in exon 9
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; common variants (e.g.,
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; known familial variants
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; duplication/deletion
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; full gene sequence
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; intron 8 poly-T analysis
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (e.g., drug metabolism), gene analysis, common
81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism), gene analysis, common
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (e.g., bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray
81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (e.g., drug metabolism), gene analysis, common variant(s)
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (e.g., drug metabolism), gene analysis, common variants
81232	DPYD (dihydropyrimidine dehydrogenase) (e.g., 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis,
81233	BTK (Bruton's tyrosine kinase) (e.g., chronic lymphocytic leukemia) gene analysis, common variants (e.g., C481S, C481R,
81234	DMPK (DM1 protein kinase) (e.g., myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded)
81235	EGFR (epidermal growth factor receptor) (e.g., non-small cell lung cancer) gene analysis, common variants (e.g., exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (e.g., myelodysplastic syndrome, myeloproliferative
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (e.g., diffuse large B-cell lymphoma) gene analysis,
81238	F9 (coagulation factor IX) (e.g., hemophilia B), full gene sequence
81239	DMPK (DM1 protein kinase) (e.g., myotonic dystrophy type 1) gene analysis; characterization of alleles (e.g., expanded
81240	F2 (prothrombin, coagulation factor II) (e.g., hereditary hypercoagulability) gene analysis, 20210G>A variant
81241	F5 (coagulation factor V) (e.g., hereditary hypercoagulability) gene analysis, Leiden variant
81242	FANCC (Fanconi anemia, complementation group C) (e.g., Fanconi anemia, type C) gene analysis, common variant (e.g.,
81243	FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; evaluation to detect abnormal
81244	FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; characterization of alleles (e.g.,
81245	FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia), gene analysis; internal tandem duplication (ITD)
81246	FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants
81247	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; common variant(s) (e.g.,
81248	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; common variant(s) (e.g.,
81249	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; full gene sequence
81250	G6PC (glucose-6-phosphatase, catalytic subunit) (e.g., Glycogen storage disease, type 1a, von Gierke disease) gene
81251	GBA (glucosidase, beta, acid) (e.g., Gaucher disease) gene analysis, common variants
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (e.g., nonsyndromic hearing loss) gene analysis; full gene
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (e.g., nonsyndromic hearing loss) gene analysis; known familial
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (e.g., nonsyndromic hearing loss) gene analysis, common variants (e.g., 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])
81255	HEXA (hexosaminidase A [alpha polypeptide]) (e.g., Tay-Sachs disease) gene analysis,
81256	HFE (hemochromatosis) (e.g., hereditary hemochromatosis) gene analysis, common variants (e.g., C282Y, H63D)
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (e.g., Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2,
81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease),
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease),
81260	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (e.g., familial
81261	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (e.g., polymerase chain reaction)

81262	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology
81263	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemia and lymphoma, B-cell), variable region somatic mutation
81264	IGK@ (Immunoglobulin kappa light chain locus) (e.g., leukemia and lymphoma, B-cell), gene rearrangement analysis,
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (e.g., pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (e.g., additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) ...
81267	Chimerism (engraftment) analysis, post transplantation specimen (e.g., hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection
81268	Chimerism (engraftment) analysis, post transplantation specimen (e.g., hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (e.g., CD3, CD33), each cell type
81270	JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant
81271	HTT (huntingtin) (e.g., Huntington disease) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (e.g., gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis
81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (e.g., mastocytosis), gene analysis, D816 variant
81274	HTT (huntingtin) (e.g., Huntington disease) gene analysis; characterization of alleles (e.g., expanded size)
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (e.g., carcinoma) gene analysis; variants in exon 2 (e.g., codons 12
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (e.g., carcinoma) gene analysis; additional variant(s) (e.g., codon 61,
81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities
81283	IFNL3 (interferon, lambda 3) (e.g., drug response), gene analysis, rs12979860 variant
81284	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles
81285	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; characterization of alleles (e.g., expanded size)
81286	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; full gene sequence
81287	MGMT (O-6-methylguanine-DNA methyltransferase) (e.g., glioblastoma multiforme) promoter methylation analysis
81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis
81289	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; known familial variant(s)
81290	MCOLN1 (mucolipin 1) (e.g., Mucolipidosis, type IV) gene analysis, common variants (
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (e.g., hereditary hypercoagulability) gene analysis, common
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81298	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full
81299	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis;
81300	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis;
81301	Microsatellite instability analysis (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (e.g., BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed
81302	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; full sequence analysis
81303	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; known familial variant
81304	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; duplication/deletion variants
81305	MYD88 (myeloid differentiation primary response 88) (e.g., Waldenstrom's macroglobulinemia, lymphoplasmacytic
81306	NUDT15 (nudix hydrolase 15) (e.g., drug metabolism) gene analysis, common variant(s) (e.g., *2, *3, *4, *5, *6)
81307	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; full gene sequence
81308	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; known familial variant
81309	PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (e.g., colorectal and breast cancer) gene analysis, targeted sequence analysis (e.g., exons 7, 9, 20)
81310	NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, exon 12 variants
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (e.g., colorectal carcinoma), gene analysis, variants in exon 2
81312	PABPN1 (poly[A] binding protein nuclear 1) (e.g., oculopharyngeal muscular dystrophy) gene analysis, evaluation to
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen])

81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (e.g., gastrointestinal stromal tumor [GIST]), gene
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (e.g., promyelocytic leukemia) translocation analysis; common breakpoints (e.g., intron 3 and intron 6), qualitative or quantitative
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (e.g., promyelocytic leukemia) translocation analysis; single breakpoint (e.g., intron 3, intron 6 or exon 6), qualitative or quantitative
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81320	PLCG2 (phospholipase C gamma 2) (e.g., chronic lymphocytic leukemia) gene analysis, common variants (e.g., R665W,
81321	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis;
81322	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis;
81323	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis;
81324	PMP22 (peripheral myelin protein 22) (e.g., Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure
81325	PMP22 (peripheral myelin protein 22) (e.g., Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure
81326	PMP22 (peripheral myelin protein 22) (e.g., Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure
81327	SEPT9 (Septin9) (e.g., colorectal cancer) promoter methylation analysis
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (e.g., adverse drug reaction), gene analysis,
81329	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; dosage/deletion analysis (e.g., carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed
81330	SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (e.g., Niemann-Pick disease, Type A) gene analysis,
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (e.g., Prader-Willi syndrome and/or Angelman syndrome), methylation analysis
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (e.g., alpha-1-antitrypsin deficiency), gene analysis, common variants (e.g., *S and *Z)
81333	TGFBI (transforming growth factor beta-induced) (e.g., corneal dystrophy) gene analysis, common variants (e.g., R124H,
81334	RUNX1 (runt related transcription factor 1) (e.g., acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (e.g., exons 3-8)
81335	TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3)
81336	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; full gene sequence
81337	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; known familial sequence
81340	TRB@ (T cell antigen receptor, beta) (e.g., leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (e.g., polymerase chain reaction)
81341	TRB@ (T cell antigen receptor, beta) (e.g., leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (e.g., Southern blot)
81342	TRG@(T cell antigen receptor, gamma) (e.g., leukemia and lymphoma), gene rearrangement analysis, evaluation to
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (e.g., spinocerebellar ataxia) gene analysis, evaluation to
81344	TBP (TATA box binding protein) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g.,
81345	TERT (telomerase reverse transcriptase) (e.g., thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted
81346	TYMS (thymidylate synthetase) (e.g., 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (e.g.,
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (e.g., drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (e.g., *28, *36, *37)
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (e.g., warfarin metabolism), gene analysis, common variant(s)
81361	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (e.g.,
81362	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
81363	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion
81364	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
81370	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1
81371	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, and -DRB1 (e.g., verification typing
81372	HLA Class I typing, low resolution (e.g., antigen equivalents); complete (i.e., HLA-A, -B, and -C
81374	HLA Class I typing, low resolution (e.g., antigen equivalents); one antigen equivalent (e.g., B*27), each
81375	HLA Class II typing, low resolution (e.g., antigen equivalents); HLA-DRB1/3/4/5 and -DQB1
81376	HLA Class II typing, low resolution (e.g., antigen equivalents); one locus (e.g., HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -
81377	HLA Class II typing, low resolution (e.g., antigen equivalents); one antigen equivalent, each
81378	HLA Class I and II typing, high resolution (i.e., alleles or allele groups), HLA-A, -B, -C, and -DRB
81379	HLA Class I typing, high resolution (i.e., alleles or allele groups); complete (i.e., HLA-A, -B, and -C
81380	HLA Class I typing, high resolution (i.e., alleles or allele groups); one locus (e.g., HLA-A, -B, or -C), each
81381	HLA Class I typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., B*57:01P)

81382	HLA Class II typing, high resolution (i.e., alleles or allele groups); one locus (e.g., HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -
81383	HLA Class II typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., HLA-DQB1*06:02P),
81400	Molecular pathology procedure, Level 1
81401	Molecular pathology procedure, Level 2
81402	Molecular pathology procedure, Level 3
81403	Molecular pathology procedure, Level 4
81404	Molecular pathology procedure, Level 5
81405	Molecular pathology procedure, Level 6
81406	Molecular pathology procedure, Level 7
81407	Molecular pathology procedure, Level 8
81408	Molecular pathology procedure, Level 9
81410	Molecular pathology procedure, Level 2
81411	Aortic dysfunction or dilation (e.g., Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and
81412	Ashkenazi Jewish associated disorders (e.g., Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1
81413	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes,
81414	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes,
81415	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81416	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81417	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (e.g., updated knowledge or unrelated condition/syndrome)
81420	Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (e.g., DiGeorge syndrome, Cri-du-chat syndrome),
81425	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81426	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81427	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (e.g., updated knowledge or unrelated condition/syndrome)
81430	Hearing loss (e.g., nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A,
81431	Hearing loss (e.g., nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes
81432	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including
81433	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and
81434	Hereditary retinal disorders (e.g., retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A,
81435	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include analysis sequencing of at least 10 genes,
81436	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1,
81437	Hereditary neuroendocrine tumor disorders (e.g., medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes,
81438	Hereditary neuroendocrine tumor disorders (e.g., medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC,
81439	Hereditary cardiomyopathy (e.g., hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-
81440	Nuclear encoded mitochondrial genes (e.g., neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG,

81442	Noonan spectrum disorders (e.g., Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1
81443	Genetic testing for severe inherited conditions (e.g., cystic fibrosis, Ashkenazi Jewish-associated disorders [e.g., Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at
81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, and RNA analysis when performed, 5-50 genes (e.g., ALK, BRAF, CDKN2A, e.g.FR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
81448	Hereditary peripheral neuropathies (e.g., Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (e.g., BSCL2, GJB1, MFN2, MPZ, REEP1,
81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (e.g., ALK, BRAF, CDKN2A, CEBPA, DNMT3A, e.g.FR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for
81460	Whole mitochondrial genome (e.g., Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire
81465	Whole mitochondrial genome large deletion analysis panel (e.g., Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection
81470	X-linked intellectual disability (XLID) (e.g., syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM,
81471	X-linked intellectual disability (XLID) (e.g., syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM,
81479	Unlisted molecular pathology procedure
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status,
81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and pre-albumin), utilizing serum, algorithm reported as a risk score
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score
81507	Fetal aneuploidy 21 18 13 seq analy trisom risk
81508	Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any form]), utilizing maternal serum,
81509	Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any form], DIA), utilizing maternal
81510	Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any form]), utilizing maternal
81511	Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include additional results from previous biochemical testing)
81512	Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant
81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination

81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival
81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score
81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue,
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score
81545	Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a
81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy
81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of
81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score
81599	Unlisted multianalyte assay with algorithmic analysis
82657	Enzyme activity in blood cells, cultured cells, or tissue, not elsewhere specified; nonradioactive substrate, each specimen
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not
84112	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (e.g., placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen
84999	Unlisted chemistry procedure
85999	Unlisted hematology and coagulation procedure
86849	Unlisted immunology procedure
86999	Unlisted transfusion medicine procedure
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each
87999	Unlisted microbiology procedure
88099	Unlisted necropsy (autopsy) procedure
88299	Unlisted cytogenetic study
88399	Unlisted surgical pathology procedure
88749	Unlisted in vivo (e.g., transcutaneous) laboratory service
89240	Unlisted miscellaneous pathology test
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than
89344	Storage (per year); reproductive tissue, testicular/ovarian
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
89398	Unlisted reproductive medicine laboratory procedure
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
90399	Unlisted immune globulin
90749	Unlisted vaccine/toxoid
90867	TMS initial
90868	TMS subsequent delivery and management
90869	TMS subsequent redetermination with delivery and management
90870	Electroconvulsive therapy
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the
90899	Unlisted psychiatric service or procedure
90901	Biofeedback training by any modality
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with
90999	Unlisted dialysis procedure, inpatient or outpatient
91110	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and

91111	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and
91299	Unlisted diagnostic gastroenterology procedure
92326	Replacement of contact lens
92499	Unlisted ophthalmological service or procedure
92700	Unlisted otorhinolaryngological service or procedure
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and
93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring;
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors,
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to
93799	Unlisted cardiovascular service or procedure
93998	Unlisted noninvasive vascular diagnostic study
94799	Unlisted pulmonary service or procedure
95199	Unlisted allergy/clinical immunologic service or procedure
95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG. technologist, minimum of 8 channels
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours;
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours;
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording

95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater
95940	Continuous intraoperative neurophysiology monitoring in the operating room
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour
95999	Unlisted neurological or neuromuscular diagnostic procedure
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language compre
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, me
96113	Each additional 30 minutes (List separately in addition to code for primary procedure)
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]),
96125	Standardized cognitive performance testing
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale)
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
96549	Unlisted chemotherapy procedure

96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (e.g., lip) by activation of photosensitive drug(s), each phototherapy exposure session
96900	Actinotherapy (ultraviolet light)
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of
96999	Unlisted special dermatological service or procedure
97028	Application of a modality to 1 or more areas; ultraviolet
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97139	Unlisted therapeutic procedure (specify)
97151	ABA Behavior identification assessment
97152	ABA Observational behavioral follow-up assessment
97153	ABA Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient.
97154	ABA Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients.
97155	ABA Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare pro
97156	ABA Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare provider (with
97157	ABA Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare
97158	ABA Adaptive behavior treatment social skills group, administered by physician or other qualified healthcare provider, fac
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing durable medical equipment
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment,
97607	Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97608	Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15
97799	Unlisted physical medicine/rehabilitation service or procedure
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per
99199	Unlisted special service, procedure or report
99429	Unlisted preventive medicine service
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission
99499	Unlisted evaluation and management service
99600	Unlisted home visit service or procedure
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or
0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation,
0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation,
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)

0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intraocular retinal
0101T	Extrcorpl Shock Wave Musckee NOS High Energy
0102T	Extracrpl Shock Wave w/Anes Lat Humer/Epcondyle
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve
0109R	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small
0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (List separately in addition to code for primary
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest
0182T	High dose rate electronic brachytherapy,
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (i.e., TEMS), including muscularis propria (i.e., full
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy,
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single
0207T	For evacuation of meibomian glands using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, use 0563T. For evacuation of meibomian gland using manual gland expression only, use the
0208T	Pure tone audiometry (threshold), automated; air only
0209T	Pure tone audiometry (threshold), automated; air and bone
0210T	Speech audiometry threshold, automated
0211T	Speech audiometry threshold, automated; with speech recognition
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s)
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s)
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s)
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed
0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal
0235T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation;
0236T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation;
0237T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation;
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the

0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg., including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg., including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg., including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency,
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency,
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image
0278T	Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each treatment session (includes
0296T	external electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (e.g.), with implantation of pulse generator, includes
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT
0333T	Visual evoked potential, screening of visual acuity, automated, with report
0335T	Insertion of sinus tarsi implant
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus
0346T	Ultrasound, elastography (List separately in addition to code for primary procedure)
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when perfo

0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, whe
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and
0353T	Optical coherence tomography of breast, surgical cavity; real-time intraoperative
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred
0355T	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report
0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior;
0376T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when
0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry,
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed
0402T	Collagen cross-linking of cornea, including removal of the corneal epithelium and intraoperative pachymetry, when
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only
0415T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system
0419T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater
0420T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities,
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral
0423T	Secretory type II phospholipase A2 (sPLA2-IIA)
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)
0425T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only
0426T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only

0427T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only
0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only
0429T	Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only
0430T	Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only
0432T	Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only
0433T	Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only
0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea
0435T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single
0436T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during
0437T	Implantation of non-biologic or synthetic implant (e.g., polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial
0443T	Real-time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (List separately
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion,
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space;
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)
0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)
0452T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular
0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface
0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface
0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)
0456T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device
0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device
0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode
0459T	Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano-
0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode
0461T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode
0462T	Programming device evaluation (in person) with iterative adjustment of the implantable mechano-electrical skin interface and/or external driver to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable aortic counterpulsation ventricular assist system, per day
0463T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)
0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure)
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing
0468T	Removal of chest wall respiratory sensor electrode or electrode array
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral
0470T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition,
0471T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (e.g., retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care
0473T	Device evaluation and interrogation of intraocular retinal electrode array (e.g., retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional

0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into
0475T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician
0476T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic
0477T	Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result
0478T	Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (e.g.,
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral
0487T	Biomechanical mapping, transvaginal, with report
0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both
0491T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface
0492T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; each additional 20 sq. cm, or part thereof (List separately in addition to code for primary procedure)
0493T	Near-infrared spectroscopy studies of lower extremity wounds (e.g., for oxyhemoglobin measurement)
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic
0496T	health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)
0498T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional per 30 days with at least one patient-generated triggered event
0499T	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis,
0500T	Infectious agent detection by nucleic acid (DNA or RNA), Human Papillomavirus (HPV) for five or more separately reported high-risk HPV types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) (i.e., genotyping)
0501T	angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile
0505T	closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with
0507T	Near infrared dual imaging (i.e., simultaneous reflective and transilluminated light) of meibomian glands, unilateral or
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia

0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)
0510T	Removal of sinus tarsi implant
0511T	Removal and reinsertion of sinus tarsi implant
0512T	ESW Integumentary Wound Healing initial Wound
0513T	ESW Integumentary Wound Healing EA Addl Wound
0514T	Intraoperative visual axis identification using patient fixation (List separately in addition to code for primary procedure)
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter)
0518T	Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac stimulator for left
0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s)
0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless
0523T	Intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded FFR values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable
0533T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; includes set-up, patient training, configuration of monitor, data upload, analysis and initial report configuration,
0534T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; set-up, patient training, configuration of monitor
0535T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; data upload, analysis and initial report configuration+
0536T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; download review, interpretation and report
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g.,
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous
0541T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles,
0542T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study; interpretation and report
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device,
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with

0547T	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score
0548T	Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy
0549T	Transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy
0550T	Transperineal periurethral balloon continence device; removal, each balloon
0551T	Transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other
0553T	Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the
0554T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and
0555T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data
0556T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone-mineral density
0557T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; interpretation and report
0558T	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an
0560T	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and
0564T	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on percent of cytotoxicity observed, a minimum of 14 drugs or drug
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral
0567T	Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach, including transvaginal
0568T	Introduction of mixture of saline and air for sonosalpingography to confirm occlusion of fallopian tubes, transcervical approach, including transvaginal ultrasound and pelvic ultrasound
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or
0572T	Insertion of substernal implantable defibrillator electrode
0573T	Removal of substernal implantable defibrillator electrode
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection,
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results
0580T	Removal of substernal implantable defibrillator pulse generator only
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local
0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic

0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed,
0588T	Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive
0591T	Health and well-being coaching face-to-face; individual, initial assessment
0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes
0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and
0596T	Temporary female intraurethral valve-pump (i.e., voiding prosthesis); initial insertion, including urethral measurement
0597T	Temporary female intraurethral valve-pump (i.e., voiding prosthesis); replacement
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (e.g., upper extremity) (List separately in addition to code for primary procedure)
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed,
0601T	Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance,
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours
0604T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and
0605T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with
0606T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; review, interpretation and report by the prescribing physician or other
0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and
0609T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (i.e., lactic acid, carbohydrate, alanine, laal, propionic acid,
0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis
0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between
0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar);
0613T	Percutaneous transcatheter implantation of interatrial septal shunt device, including right and left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed
0614T	Removal and replacement of substernal implantable defibrillator pulse generator
0615T	Eye-movement analysis without spatial calibration, with interpretation and report
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete
0621T	Trabeculostomy ab interno by laser

0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups,
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition,
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service
0008U	Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin-embedded or fresh tissue or fecal sample, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline, and
0009U	Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin-fixed paraffin-embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified
0010U	Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain
0011U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds
0012U	Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood,
0013U	Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)
0014U	Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)
0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected
0018U	Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy
0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents
0021U	Oncology (prostate), detection of 8 autoantibodies (ARF 6, NKX3-1, 5'-UTR-BMI1, CEP 164, 3'-UTR-Ropporin, Desmocollin, AURKAIP-1, CSNK2A2), multiplexed immunoassay and flow cytometry serum, algorithm reported as risk
0022U	Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to
0023U	Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of

0024U	Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative
0025U	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low
0027U	JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (i.e., CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (i.e., CYP2C9, CYP4F2, VKORC1, rs12777823)
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(e.g., drug metabolism) gene analysis, common variants
0032U	COMT (catechol-O-methyltransferase)(e.g., drug metabolism) gene analysis, c.472G>A (rs4680) variant
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (e.g., citalopram metabolism) gene analysis, common variants (i.e., HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334
0034U	TPMT (thiopurine S-methyltransferase), NUDT15 (nude hydroxylase 15)(e.g., thiopurine metabolism) gene analysis, common variants (i.e., TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5)
0035U	Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quakinginduced conformational conversion,
0036U	Exome (i.e., somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational
0038U	Vitamin D, 25 hydroxy D2 and D3, by LCMS/MS, serum microsample, quantitative
0039U	Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity
0040U	BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative
0041U	Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM
0042U	Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG
0043U	Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM
0044U	Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by realtime RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence
0046U	FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia) internal tandem duplication (ITD) variants,
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing
0049U	NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, quantitative
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
0051U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation
0053U	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism
0056U	Hematology (acute myelogenous leukemia), DNA, whole genome nextgeneration sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)
0058U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T
0059U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum,
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal
0061U	Transcutaneous measurement of five biomarkers (tissue oxygenation [StO2], oxyhemoglobin [ctHbO2], deoxyhemoglobin [ctHbR], papillary and reticular dermal hemoglobin concentrations [ctHb1 and ctHb2]), using spatial
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm
0063U	Neurology (autism), 32 amines by LCMS/MS, using plasma, algorithm reported as metabolic signature associated with
0064U	Antibody, Treponema pallidum, total and rapid plasma reagin (RPR), immunoassay, qualitative
0065U	Syphilis test, non-treponemal antibody, immunoassay, qualitative (RPR)
0066U	Placental alpha-micro globulin-1 (PAMG-1), immunoassay with direct optical observation, cervico-vaginal fluid, each

0067U	Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm
0068U	Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C. tropicalis, and C. auris), amplified probe technique with qualitative report of the presence or absence of each species
0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue,
0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, common and select rare variants (i.e., *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41,
0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, full gene
0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted
0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted
0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., non-duplicated gene when duplication/multiplication is trans)
0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., 5' gene duplication/multiplication)
0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., 3' gene duplication/ multiplication)
0077U	Immunoglobulin paraprotein (M-protein), qualitative, immunoprecipitation and mass spectrometry, blood or urine,
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (i.e., ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for
0080U	Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule
0082U	Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions
0083U	Oncology, response to chemotherapy drugs using motility contrast tomography, fresh or frozen tissue, reported as likelihood of sensitivity or resistance to drugs or drug combinations
0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell
0086U	Infectious disease (bacterial and fungal), organism identification, blood culture, using rRNA FISH, 6 or more organism targets, reported as positive or negative with phenotypic minimum inhibitory concentration (MIC)-based antimicrobial
0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score
0088U	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using
0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (i.e., benign,
0091U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result
0092U	Oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm
0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not
0094U	Genome (e.g., unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis
0095U	Inflammation (eosinophilic esophagitis), ELISA analysis of eotaxin-3 (CCL26 [C-C motif chemokine ligand 26]) and major basic protein (PRG2 [proteoglycan 2, pro eosinophil major basic protein]), specimen obtained by swallowed nylon string,
0096U	Human papillomavirus (HPV), high-risk types (i.e., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68), male urine
0097U	subtypes, 22 targets (Campylobacter [C. jejuni/C. coli/C. upsaliensis], Clostridium difficile [C. difficile] toxin A/B, Plesiomonas shigelloides, Salmonella, Vibrio [V. parahaemolyticus/V. vulnificus/V. cholerae], including specific identification of Vibrio cholerae, Yersinia enterocolitica, Enteroaggregative Escherichia coli [EAEC], Enteropathogenic Escherichia coli [EPEC], Enterotoxigenic Escherichia coli [ETEC] lt/st, Shiga-like toxin-producing Escherichia coli [STEC] stx1/stx2 [including specific identification of the E. coli O157 serogroup within STEC], Shigella/Enteroinvasive Escherichia coli [EIEC], Cryptosporidium, Cyclospora cayetanensis, Entamoeba histolytica, Giardia lamblia [also known as G.
0101U	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and
0102U	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and

0103U	Hereditary ovarian cancer (e.g., hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])
0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion
0107U	Clostridium difficile toxin(s) antigen detection by immunoassay technique, stool, qualitative, multiple-step method
0108U	Gastroenterology (Barrett's esophagus), whole slide-digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1a, HER-2, K20) and morphology, formalin-fixed paraffin-embedded tissue, algorithm reported as risk of progression to high-grade
0109U	Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (A. fumigatus, A. terreus, A. niger, and A. flavus), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species
0110U	Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state
0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance
0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as
0115U	Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as
0116U	Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug to drug interactions for prescribed
0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LCMS/MS, urine, algorithm reported as a
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA
0119U	Cardiology, ceramides by liquid chromatography-tandem mass spectrometry, plasma, quantitative report with risk score
0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of
0121U	Sickle cell disease, microfluidic flow adhesion (VCAM-1), whole blood
0122U	Sickle cell disease, microfluidic flow adhesion (P-Selectin), whole blood
0123U	Mechanical fragility, RBC, shear stress and spectral analysis profiling
0129U	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1,
0130U	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH,
0131U	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes)
0132U	Hereditary ovarian cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes)
0133U	Hereditary prostate cancer-related disorders, targeted mRNA sequence analysis panel (11 genes)
0134U	Hereditary pan cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure
0135U	Hereditary gynecological cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary
0136U	ATM (ataxia telangiectasia mutated) (e.g., ataxia telangiectasia) mRNA sequence analysis (List separately in addition to
0137U	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) mRNA sequence analysis
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian
0139U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 6 central carbon metabolites (i.e., αketoglutarate, alanine, lactate, phenylalanine, pyruvate, and succinate), LC-MS/MS, plasma, algorithmic analysis with
0140U	Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected

0141U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture, amplified probe technique, each target reported as detected or not detected
0142U	Infectious disease (bacteria and fungi), gram-negative bacterial identification and drug resistance element detection, DNA (21 gram-negative bacterial targets, 6 resistance genes, 1 pan gram-positive bacterial target, 1 pan Candida target),
0143U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0144U	Drug assay, definitive, 160 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0145U	Drug assay, definitive, 65 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0146U	Drug assay, definitive, 80 or more drugs or metabolites, urine, by quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0147U	Drug assay, definitive, 85 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0148U	Drug assay, definitive, 100 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0149U	Drug assay, definitive, 60 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0150U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments
0151U	Infectious disease (bacterial or viral respiratory tract infection), pathogen specific nucleic acid (DNA or RNA), 33 targets, real-time semi-quantitative PCR, bronchoalveolar lavage, sputum, or endotracheal aspirate, detection of 33 organismal
0152U	Infectious disease (bacteria, fungi, parasites, and DNA viruses), DNA, PCR and next-generation sequencing, plasma, detection of >1,000 potential microbial organisms for significant positive pathogens
0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on
0154U	Oncology (urothelial cancer), RNA, analysis by real-time RT-PCR of the FGFR3 (fibroblast growth factor receptor 3) gene analysis (i.e., p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1, and FGFR3-TACC3v3) utilizing formalin-fixed paraffin-embedded urothelial cancer tumor tissue, reported as FGFR gene
0155U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3- kinase, catalytic subunit alpha) (e.g., breast cancer) gene analysis (i.e., p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.E545G, p.E545K, p.Q546E, p.Q546R, p.H1047L, p.H1047R, p.H1047Y), utilizing formalin-fixed paraffinembedded breast tumor tissue, reported as
0156U	Copy number (e.g., intellectual disability, dysmorphology), sequence analysis
0157U	APC (APC regulator of WNT signaling pathway) (e.g., familial adenomatosis polyposis [FAP]) mRNA sequence analysis
0158U	MLH1 (mutL homolog 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis
0159U	MSH2 (mutS homolog 2) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis
0160U	MSH6 (mutS homolog 6) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (e.g., hereditary nonpolyposis colorectal cancer, Lynch
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2)
0163U	Oncology (colorectal) screening, biochemical enzyme-linked immunosorbent assay (ELISA) of 3 plasma or serum proteins (teratocarcinoma derived growth factor-1 [TDGF-1, Cripto1], carcinoembryonic antigen [CEA], extracellular matrix protein [ECM]), with demographic data (age, gender, CRCscreening compliance) using a proprietary algorithm
0164U	Gastroenterology (irritable bowel syndrome [IBS]), immunoassay for antiCdtB and anti-vinculin antibodies, utilizing plasma, algorithm for elevated or not elevated qualitative results
0165U	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, individual epitope results and probability of peanut allergy
0166U	Liver disease, 10 biochemical assays (α2- macroglobulin, haptoglobin, apolipoprotein A1, bilirubin, GGT, ALT, AST, triglycerides, cholesterol, fasting glucose) and biometric and demographic data, utilizing serum, algorithm reported as
0167U	Gonadotropin, chorionic (hCG), immunoassay with direct optical observation, blood
0168U	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma without fetal fraction cutoff, algorithm reported as a risk score for each trisomy
0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism) gene analysis,
0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease,

0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-
0173U	Psychiatry (i.e., depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes
0174U	Oncology (solid tumor), mass spectrometric 30 protein targets, formalin-fixed paraffin-embedded tissue, prognostic and predictive algorithm reported as likely, unlikely, or uncertain benefit of 39 chemotherapy and targeted therapeutic
0175U	Psychiatry (e.g., depression, anxiety), genomic analysis panel, variant analysis of 15 genes
0176U	Cytolethal distending toxin B (CdtB) and vinculin IgG antibodies by immunoassay (i.e., ELISA)
0177U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3- kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status
0178U	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, report of minimum eliciting exposure for a clinical reaction
0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations),
0180U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/conventional sequencing, ABO (ABO, alpha 1-3-Nacetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene, including subtyping, 7
0181U	Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1
0182U	Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group])
0183U	Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego
0184U	Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock
0185U	Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4
0186U	Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2
0187U	Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood
0188U	Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group])
0189U	Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns
0190U	Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns
0191U	Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons
0192U	Red cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd
0193U	Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2
0194U	Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group])
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (i.e., exon 13)
0196U	Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran
0197U	Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion
0198U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5
0199U	Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated
0200U	Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (Xlinked Kx blood group) exons 1-3
0201U	Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group])
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab,
0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory
0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected
0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negative for neovascular age-related macular-degeneration risk
0206U	Neurology (Alzheimer disease); cell aggregation using morphometric imaging and protein kinase C-epsilon (PKCe) concentration in response to amylospheroid treatment by ELISA, cultured skin fibroblasts, each reported as positive or
0207U	Neurology (Alzheimer disease); quantitative imaging of phosphorylated ERK1 and ERK2 in response to bradykinin treatment by in situ immunofluorescence, using cultured skin fibroblasts, reported as a probability index for Alzheimer
0208U	Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities
0210U	Syphilis test, non-treponemal antibody, immunoassay, quantitative (RPR
0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely

0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (e.g.,
0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely
0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (e.g.,
0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or
0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva,
0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of
0219U	Infectious agent (human immunodeficiency virus), targeted viral next-generation sequence analysis (i.e., protease [PR], reverse transcriptase [RT], integrase [INT]), algorithm reported as prediction of antiviral drug susceptibility
0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and
0221U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis, next-generation sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene
0222U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis, next-generation sequencing, RH proximal
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab,
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARSCoV-2), amplified probe technique, including multiplex reverse
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus
0227U	Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes
0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morning voided urine, algorithm reported as likelihood of
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (e.g., colorectal cancer)
0230U	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (e.g., spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene
0232U	CSTB (cystatin B) (e.g., progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR)
0233U	FXN (frataxin) (e.g., Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely
0234U	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable
0235U	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element
0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (e.g., spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications and deletions,
0237U	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions,
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each

0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite
0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage
0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red
0247U	Obstetrics (preterm birth), insulin-like growth factor–binding protein 4 (IBP4), sex hormone–binding globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A4351	Intermittent urinary catheter; straight tip
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomeric, or
A4353	Intermittent urinary catheter, with insertion supplies
A4638	Replacement battery for patient-owned ear pulse generator, each
A5500	For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi- density insert(s), per shoe
A5501	For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's
A5503	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set
A5507	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-
A5508	For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe
A5512	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a
A5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and
A5514	For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated,
A6210	Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive
A6211	Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6501	Compression burn garment, bodysuit (head to foot), custom fabricated
A6502	Compression burn garment, chin strap, custom fabricated
A6503	Compression burn garment, facial hood, custom fabricated
A6504	Compression burn garment, glove to wrist, custom fabricated
A6505	Compression burn garment, glove to elbow, custom fabricated
A6506	Compression burn garment, glove to axilla, custom fabricated
A6507	Compression burn garment, foot to knee length, custom fabricated
A6508	Compression burn garment, foot to thigh length, custom fabricated
A6509	Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated
A6510	Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated
A6511	Compression burn garment, lower trunk including leg openings (panty), custom fabricated
A6513	Compression burn mask, face and/or neck, plastic or equal, custom fabricated
A6530	Gradient compression stocking, below knee, 18-30 mmhg, each
A6531	Gradient compression stocking, below knee, 30-40 mmhg, each
A6532	Gradient compression stocking, below knee, 40-50 mmhg, each
A6533	Gradient compression stocking, thigh length, 18-30 mmhg, each
A6534	Gradient compression stocking, thigh length, 30-40 mmhg, each
A6535	Gradient compression stocking, thigh length, 40-50 mmhg, each
A6536	Gradient compression stocking, full length/chap style, 18-30 mmhg, each
A6537	Gradient compression stocking, full length/chap style, 30-40 mmhg, each
A6538	Gradient compression stocking, full length/chap style, 40-50 mmhg, each

A6539	Gradient compression stocking, waist length, 18-30 mmhg, each
A6540	Gradient compression stocking, waist length, 30-40 mmhg, each
A6541	Gradient compression stocking, waist length, 40-50 mmhg, each
A6544	Gradient compression stocking, garter belt
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mm hg, each
A6549	Gradient compression stocking/sleeve, not otherwise specified
A7025	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each
A7048	Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with
A8002	Helmet, protective, soft, custom fabricated, includes all components and accessories
A8003	Helmet, protective, hard, custom fabricated, includes all components and accessories
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
A9582	Iodine i-123 iobenguane, diagnostic, per study dose, up to 15 millicuries
B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set
B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set
B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit
B4104	Additive for enteral formula (e.g. fiber)
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination,
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube,
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix
B4185	Parenteral nutrition solution, not otherwise specified, 10 grams lipids
B5200	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix
B9002	Enteral nutrition infusion pump, any type
B9004	Parenteral nutrition infusion pump, portable
B9006	Parenteral nutrition infusion pump, stationary
B9998	Noc for enteral supplies
B9999	Noc for parenteral supplies
C1764	Event recorder, cardiac (implantable)
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1789	Breast Implant

C1821	Interspinous process distraction device (implantable)
C1878	Material for vocal cord medialization, synthetic (implantable)
C8908	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
E0202	Phototherapy light w/photom
E0217	Water circulating heat pad with pump
E0247	Transfer bench for tub or toilet with or without commode opening
E0250	Hosp bed fixed ht w/ mattress
E0251	Hosp bed fixed ht w/o mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0256	Hospital bed var ht w/o matt
E0260	Hospital bed var ht w/o matt
E0261	Hosp bed semi-electr w/o mat
E0265	Hosp bed total electr w/ mat
E0266	Hosp bed total elec w/o matt
E0270	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails,
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with
E0305	Bed side rails, half length
E0310	Bed side rails, full length
E0316	Safety enclosure frame/canopy for use with hospital bed, any type
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches
E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device
E0483	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated,
E0562	Humidifier, heated, used with positive airway pressure device
E0600	Respiratory suction pump, home model, portable or stationary, electric
E0601	Continuous positive airway pressure (cpap) device
E0616	Implantable cardiac event recorder with memory, activator and programmer
E0619	Apnea Monitor
E0638	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric
E0650	Pneumatic compressor, non-segmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk

E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg.
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg.
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg.
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg.
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk
E0671	Segmental gradient pressure pneumatic appliance, full leg.
E0672	Segmental gradient pressure pneumatic appliance, full arm
E0673	Segmental gradient pressure pneumatic appliance, half leg.
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection
E0730	Transcutaneous electrical nerve stimulation (tens) device, four or more leads, for multiple nerve stimulation
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment,
E0784	External ambulatory infusion pump, insulin
E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
E0849	Traction equipment, cervical, free-standing stand/frame, pneumatic,
E0935	Continuous passive motion exercise device for use on knee only
E0950	Wheelchair accessory, tray, each
E0951	Heel loop/holder, any type, with or without ankle strap, each (COST DEPENDENT)
E0952	Toe loop/holder, any type, each
E0953	Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each
E0954	Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each
E0958	Manual wheelchair accessory, one-arm drive attachment, each
E0959	Manual wheelchair accessory, adapter for amputee, each
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each
E0966	Manual wheelchair accessory, headrest extension, each
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each
E0968	Commode seat, wheelchair
E0969	Narrowing device, wheelchair
E0970	No. 2 footplates, except for elevating leg rest
E0971	Manual wheelchair accessory, anti-tipping device, each
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each
E0974	Manual wheelchair accessory, anti-rollback device, each
E0978	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each
E0980	Safety vest, wheelchair
E0981	Wheelchair accessory, seat upholstery, replacement only, each
E0982	Wheelchair accessory, back upholstery, replacement only, each
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control
E0984	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986	Manual wheelchair accessory, push-rim activated power assist system
E0990	Wheelchair accessory, elevating leg. rest, complete assembly, each
E0992	Manual wheelchair accessory, solid seat insert
E0994	Arm rest, each

E0995	Wheelchair accessory, calf rest/pad, replacement only, each
E1002	Wheelchair accessory, power seating system, tilt only
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction
E1005	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod
E1010	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod
E1011	Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete
E1014	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete
E1015	Shock absorber for manual wheelchair, each
E1016	Shock absorber for power wheelchair, each
E1017	Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each
E1018	Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each
E1020	Residual limb support system for wheelchair, any type
E0128	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control
E1029	Wheelchair accessory, ventilator tray, fixed
E1050	Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1060	Fully-reclining wheelchair, detachable arms, desk or full length, swing away detachable elevating leg rests
E1070	Fully-reclining wheelchair, detachable arms (desk or full length) swing away detachable foot rest
E1083	Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest
E1084	Hemi-wheelchair, detachable arms desk or full length arms, swing away detachable elevating leg rests
E1085	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests
E1086	Hemi-wheelchair detachable arms desk or full length, swing away detachable foot rests
E1087	High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1088	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests
E1089	High strength lightweight wheelchair, fixed length arms, swing away detachable footrest
E1090	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable foot rests
E1092	Wide heavy duty wheel chair, detachable arms (desk or full length), swing away detachable elevating leg rests
E1093	Wide heavy duty wheelchair, detachable arms desk or full length arms, swing away detachable foot rests
E1100	Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1110	Semi-reclining wheelchair, detachable arms (desk or full length) elevating leg rest
E1130	Standard wheelchair, fixed full length arms, fixed or swing away detachable foot rests
E1140	Wheelchair, detachable arms, desk or full length, swing away detachable foot rests
E1150	Wheelchair, detachable arms, desk or full length swing away detachable elevating leg rests
E1160	Wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1161	Manual adult size wheelchair, includes tilt in space
E1170	Amputee wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1171	Amputee wheelchair, fixed full length arms, without foot rests or leg rest
E1172	Amputee wheelchair, detachable arms (desk or full length) without foot rests or leg rest
E1180	Amputee wheelchair, detachable arms (desk or full length) swing away detachable foot rests
E1190	Amputee wheelchair, detachable arms (desk or full length) swing away detachable elevating leg rests
E1195	Heavy duty wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1200	Amputee wheelchair, fixed full length arms, swing away detachable foot rest
E1220	Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification
E1221	Wheelchair with fixed arm, foot rests
E1222	Wheelchair with fixed arm, elevating leg rests
E1223	Wheelchair with detachable arms, foot rests
E1224	Wheelchair with detachable arms, elevating leg rests
E1225	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each
E1226	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each
E1227	Special height arms for wheelchair
E1228	Special back height for wheelchair
E1229	Wheelchair, pediatric size, not otherwise specified
E1230	Power operated vehicle (three or four wheel nonhighway) specify brand name and model number

E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
E1235	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
E1236	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1239	Wheelchair, pediatric size, folding, adjustable, without seating system
E1240	Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating leg rest
E1250	Lightweight wheelchair, fixed full length arms, swing away detachable foot rest
E1260	Lightweight wheelchair, detachable arms (desk or full length) swing away detachable foot rest
E1270	Lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests
E1280	Heavy duty wheelchair, detachable arms (desk or full length) elevating leg rests
E1285	Heavy duty wheelchair, detachable arms (desk or full length) elevating leg rests
E1290	Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable foot rest
E1295	Heavy duty wheelchair, fixed full length arms, elevating leg rest
E1296	Special wheelchair seat height from floor
E1297	Special wheelchair seat depth, by upholstery
E1298	Special wheelchair seat depth and/or width, by construction
E1399	Durable medical equipment, miscellaneous
E2120	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid
E2206	Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each
E2211	Manual wheelchair accessory, pneumatic propulsion tire, any size, each
E2213	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each
E2300	Wheelchair accessory, power seat elevation system, any type
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed
E2312	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control
E2402	Negative pressure wound therapy electrical pump, stationary or portable
E2500	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple
E2511	Speech generating software program, for personal computer or personal digital assistant
E2512	Accessory for speech generating device, mounting system
E2599	Accessory for speech generating device, not otherwise classified
E2609	Custom fabricated wheelchair seat cushion, any size
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
G0151	Services performed by a qualified physical therapist in the home health or hospice setting,
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting,
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings,
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes

G0162	Skilled services by a registered nurse (rn) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an rn to ensure that essential non-skilled care achieves its
G0166	External counterpulsation, per treatment session
G0179	Physician re-certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period
G0180	Physician certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to
G0181	(patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar
G0182	multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0219	Pet imaging whole body; melanoma for non-covered indications
G0235	Pet imaging, any site, not otherwise specified
G0238	Therapeutic procedures to improve respiratory function, other than described by g0237, one on one, face to face, per
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two
G0249	Provision of test materials and equipment for home inr monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once
G0252	Pet imaging, full and partial-ring pet scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g. initial staging of axillary lymph nodes
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
G0299	Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a license practical nurse (lpn) in the home health or hospice setting, each 15 minutes
G0302	Pre-operative pulmonary surgery services for preparation for lvrs, complete course of services, to include a minimum of
G0303	Pre-operative pulmonary surgery services for preparation for lvrs, 10 to 15 days of services
G0304	Pre-operative pulmonary surgery services for preparation for lvrs, 1 to 9 days of services
G0305	Post-discharge pulmonary surgery services after lvrs, minimum of 6 days of services
G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (lds) (e.g., as a result of highly active
G0455	Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen
G0480	structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es),
G0481	structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es),
G0482	structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es),

G0483	structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug
G0494	Skilled services of a licensed practical nurse (lpn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's
G0495	Skilled services of a registered nurse (rn), in the training and/or education of a patient or family member, in the home
G0496	Skilled services of a licensed practical nurse (lpn), in the training and/or education of a patient or family member, in the
G2082	Up to 56 mg of esketamine nasal self-administration, includes 2 hours post observation
G2083	Greater than 56 mg esketamine nasal self-administration, includes 2 hours post-observation
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina, 5 units
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a, 1 unit
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength, lightweight wheelchair
K0005	Ultralightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0008	Custom manual wheelchair/base
K0009	Other manual wheelchair/base
K0010	Standard - weight frame motorized/power wheelchair
K0011	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom motorized/power wheelchair base
K0014	Other motorized/power wheelchair base
K0040	Adjustable angle footplate, each
K0108	Wheelchair component or accessory, not otherwise specified
K0195	Elevating leg. rests, pair (for use with capped rental wheelchair base)
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0739	Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow
K0800	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pound
K0802	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle, not otherwise classified
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300
K0814	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300
K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0823	Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pound

K0826	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pound
K0827	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
K0829	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more
K0830	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more
K0831	Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and
K0836	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450
K0838	Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and
K0842	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and
K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851	Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853	Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and
K0857	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869	Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds
K0870	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and
K0878	Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including
K0879	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450
K0880	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and
K0885	Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including
K0886	Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and
K0898	Power wheelchair, not otherwise classified
K0899	Power mobility device, not coded by dme pdac or does not meet criteria
L0112	Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion
L0220	Thoracic, rib belt, custom fabricated
L0452	Tlso, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated
L0480	Tlso, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse
L0482	Tlso, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes,

L0484	Tlso, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal,
L0486	Tlso, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal,
L0622	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated
L0624	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom
L0629	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may
L0632	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps,
L0634	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps,
L0636	Lumbar sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps,
L0638	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps,
L0640	Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes
L0648	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0650	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps,
L1005	Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment
L1630	Hip orthosis, abduction control of hip joints, semi-flexible (von rosen type), custom fabricated
L1640	Hip orthosis, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated
L1680	Hip orthosis, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (rancho
L1685	Hip orthosis, abduction control of hip joint, postoperative hip abduction type, custom fabricated
L1700	Legg perthes orthosis, (toronto type), custom fabricated
L1710	Legg perthes orthosis, (newington type), custom fabricated
L1720	Legg perthes orthosis, trilateral, (tachdijan type), custom fabricated
L1730	Legg perthes orthosis, (scottish rite type), custom fabricated
L1755	Legg perthes orthosis, (patten bottom type), custom fabricated
L1820	Knee orthosis, elastic with condylar pads and joints,
L1832	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with
L1833	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the
L1834	Knee orthosis, without knee joint, rigid, custom fabricated
L1840	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated
L1844	Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated
L1846	Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated
L1851	Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf
L1852	Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf
L1860	Knee orthosis, modification of supracondylar prosthetic socket, custom fabricated
L1900	Ankle foot orthosis, spring wire, dorsiflexion assist calf band, custom fabricated

L1902	Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf
L1904	Ankle orthosis, ankle gauntlet or similar, with or without joints, custom fabricated
L1906	Ankle foot orthosis, multiligamentous ankle support, prefabricated, off-the-shelf
L1907	Ankle orthosis, supramalleolar with straps, with or without interface/pads, custom fabricated
L1910	Ankle foot orthosis, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and
L1920	Ankle foot orthosis, single upright with static or adjustable stop (phelps or perlstein type), custom fabricated
L1930	Ankle foot orthosis, plastic or other material, prefabricated, includes fitting and adjustment
L1932	Afo, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment
L1940	Ankle foot orthosis, plastic or other material, custom fabricated
L1945	Ankle foot orthosis, plastic, rigid anterior tibial section (floor reaction), custom fabricated
L1950	Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic, custom fabricated
L1951	Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated,
L1960	Ankle foot orthosis, posterior solid ankle, plastic, custom fabricated
L1970	Ankle foot orthosis, plastic with ankle joint, custom fabricated
L1971	Ankle foot orthosis, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
L1980	Ankle foot orthosis, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar 'bk' orthosis), custom
L1990	Ankle foot orthosis, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar 'bk' orthosis),
L2000	Knee ankle foot orthosis, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'ak'
L2005	Knee ankle foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated
L2006	Knee ankle foot device, any material, single or double upright, swing and stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle
L2010	Knee ankle foot orthosis, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'ak' orthosis),
L2020	Knee ankle foot orthosis, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar 'ak' orthosis),
L2030	Knee ankle foot orthosis, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar 'ak' orthosis),
L2034	Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated
L2035	Knee ankle foot orthosis, full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and
L2036	Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with or without free motion
L2037	Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, with or without free motion
L2038	Knee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated
L2040	Hip knee ankle foot orthosis, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated
L2050	Hip knee ankle foot orthosis, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated
L2060	Hip knee ankle foot orthosis, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/ belt, custom
L2070	Hip knee ankle foot orthosis, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated
L2080	Hip knee ankle foot orthosis, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated
L2090	Hip knee ankle foot orthosis, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/ belt, custom
L2106	Ankle foot orthosis, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated
L2108	Ankle foot orthosis, fracture orthosis, tibial fracture cast orthosis, custom fabricated
L2112	Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment
L2114	Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2116	Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment
L2126	Knee ankle foot orthosis, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom
L2128	Knee ankle foot orthosis, fracture orthosis, femoral fracture cast orthosis, custom fabricated
L2232	Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis
L2320	Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2350	Addition to lower extremity, prosthetic type, (bk) socket, molded to patient model, (used for 'ptb' 'afo' orthoses)
L2387	Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint
L2520	Addition to lower extremity, thigh/weight bearing, quadri- lateral brim, custom fitted
L2526	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow m-l brim, custom fitted
L2755	Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg. composite, per
L2800	Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated
L2861	Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated
L3000	Foot, insert, removable, molded to patient model, 'ucb' type, berkeley shell, each
L3001	Foot, insert, removable, molded to patient model, spenco, each
L3002	Foot, insert, removable, molded to patient model, plastazote or equal, each
L3003	Foot, insert, removable, molded to patient model, plastazote or equal, each

L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each
L3030	Foot, insert, removable, formed to patient foot, each
L3031	Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid
L3040	Foot, arch support, removable, premolded, longitudinal, each
L3050	Foot, arch support, removable, premolded, metatarsal, each
L3160	Foot, adjustable shoe-styled positioning device
L3170	Foot, plastic, silicone or equal, heel stabilizer, prefabricated, off-the-shelf, each
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each
L3252	Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each
L3253	Foot, molded shoe plastazote (or similar) custom fitted, each
L3671	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes
L3674	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, with or without nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3702	Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3720	Elbow orthosis, double upright with forearm/arm cuffs, free motion, custom fabricated
L3730	Elbow orthosis, double upright with forearm/arm cuffs, extension/ flexion assist, custom fabricated
L3740	Elbow orthosis, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated
L3760	Elbow orthosis, with adjustable position locking joint(s), prefabricated
L3763	Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and
L3764	Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3765	Elbow wrist hand finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes
L3766	Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes
L3891	Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated
L3900	Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, wrist or
L3901	Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, cable
L3904	Wrist hand finger orthosis, external powered, electric, custom fabricated
L3905	Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3906	Wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and
L3913	Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and
L3919	Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3921	Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3933	Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3935	Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment
L3961	Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom
L3967	Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3971	Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3973	Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated,
L3975	Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps,
L3976	Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977	Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978	Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom
L4030	Replace quadrilateral socket brim, custom fitted
L4040	Replace molded thigh lacer, for custom fabricated orthosis only
L4045	Replace non-molded thigh lacer, for custom fabricated orthosis only

L4050	Replace molded calf lacer, for custom fabricated orthosis only
L4055	Replace non-molded calf lacer, for custom fabricated orthosis only
L4396	Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to
L4397	Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, off-the-shelf
L4398	Foot drop splint, recumbent positioning device, prefabricated, off-the-shelf
L4631	Ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated
L5000	Partial foot, shoe insert with longitudinal arch, toe filler
L5312	Knee disarticulation (or through knee), molded socket, single axis knee, pylon, sach foot, endoskeletal system
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame
L5673	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
L5679	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
L5681	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other
L5683	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only
L5685	Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each
L5704	Custom shaped protective cover, below knee
L5705	Custom shaped protective cover, above knee
L5706	Custom shaped protective cover, knee disarticulation
L5707	Custom shaped protective cover, hip disarticulation
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5845	Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and
L5857	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and
L5858	Addition to lower extremity, socket insert, above knee (kemblo, pelite, aliplast, plastazote or equal)
L5970	All lower extremity prostheses, foot, external keel, sach foot
L5974	All lower extremity prostheses, foot, single axis ankle/foot
L5981	All lower extremity prostheses, flex-walk system or equal
L5999	Lower extremity prosthesis, not otherwise specified
L6611	Addition to upper extremity prosthesis, external powered, additional switch, any type
L6677	Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow
L6694	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
L6695	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
L6696	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only
L6697	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism,
L6880	Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of
L6881	Automatic grasp feature, addition to upper limb electric prosthetic terminal device
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device
L6895	Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device

L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6955	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger,
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger,
L7007	Electric hand, switch or myoelectric controlled, adult
L7008	Electric hand, switch or myoelectric controlled, adult
L7009	Electric hook, switch or myoelectric controlled, adult
L7040	Prehensile actuator, switch controlled
L7045	Electric hook, switch or myoelectric controlled, adult
L7170	Electronic elbow, hosmer or equal, switch controlled
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device
L7181	Electronic elbow, microprocessor simultaneous control of elbow and terminal device
L7185	Electronic elbow, adolescent, variety village or equal, switch controlled
L7186	Electronic elbow, child, variety village or equal, switch controlled
L7190	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled
L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled
L7259	Electronic wrist rotator, any type
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each
L8035	Custom breast prosthesis, post mastectomy, molded to patient model
L8600	Implantable breast prosthesis, silicone or equal
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies
L8614	Cochlear device, includes all internal and external components
L8618	Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement
L8619	Coch implant trans coil repl
L8627	Cochlear implant, external speech processor, component, replacement
L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement
L8680	Implantable Neurostimulator Electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8690	Auditory osseointegrated device, includes all internal and external components
L8691	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each
L8692	Auditory Osseo integrated device, external sound processor, used without osseointegration, body worn, includes
L8693	Auditory osseointegrated device abutment, any length, replacement only
L8699	Prosthetic implant, not otherwise specified
L8701	Elbow, wrist, hand device, powered, with single or double upright(s), any type joint(s), includes microprocessor, sensors,
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use)
Q4132	Grafix core, per square centimeter
Q4133	Grafix prime, per square centimeter
Q5001	Hospice or home health care provided in patient's home/residence
S1002	Customized item (list in addition to code for basic item)
S1040	Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and
S2066	Breast reconstruction with gluteal artery perforator (gap) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a Breast, unilateral

S2067	Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (diep) flap(s) and/or gluteal artery perforator (gap) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and
S2068	Breast reconstruction with deep inferior epigastric perforator (diep) flap or superficial inferior epigastric artery (siea) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast,
S2080	Laser-assisted uvulopalatoplasty (laup)
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline
S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components
S2202	Echosclerotherapy
S3840	DNA analysis for germline mutations of the ret proto-oncogene for susceptibility to multiple endocrine neoplasia type 2
S3841	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination
S3842	Genetic testing for von hippel-lindau disease
S3844	Genetic testing for von hippel-lindau disease
S3845	Genetic testing for alpha-thalassemia
S3846	Genetic testing for hemoglobin e beta-thalassemia
S3849	Genetic testing for Niemann-pick disease
S3850	Genetic testing for sickle cell anemia
S3852	DNA analysis for apoe epsilon 4 allele for susceptibility to Alzheimer’s disease
S3853	Genetic testing for myotonic muscular dystrophy
S3854	Gene expression profiling panel for use in the management of breast cancer treatment
S3861	Genetic testing, sodium channel, voltage-gated, type v, alpha subunit (scn5a) and variants for suspected brugada syndrome
S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (hcm) in an individual with a known hcm mutation in the family
S3870	Comparative genomic hybridization (cgh) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability
S8420	Gradient pressure aid (sleeve and glove combination), custom made
S8422	Gradient pressure aid (sleeve), custom made, medium weight
S8423	Gradient pressure aid (sleeve), custom made, heavy weight
S8425	Gradient pressure aid (glove), custom made, medium weight
S8426	Gradient pressure aid (glove), custom made, heavy weight
S9098	Home phototherapy visit
S9122	Home health aide or certified nurse assistant, providing care in the home; per hour
S9123	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when cpt
S9124	Nursing care, in the home; by licensed practical nurse, per hour
S9125	Respite care, in the home, per diem
S9126	Hospice care, in the home, per diem
S9128	Speech therapy, in the home, per diem
S9129	Occupational therapy, in the home, per diem
S9131	Physical therapy; in the home, per diem
S9435	Medical foods for inborn errors of metabolism
S9500	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits
T1000	Private duty / independent nursing service(s) - licensed, up to 15 minutes
T1002	Rn services, up to 15 minutes
T1003	Lpn/lvn services, up to 15 minutes
T1005	Respite care services, up to 15 minutes
T1030	Nursing care, in the home, by registered nurse, per diem
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
V2623	Prosthetic eye, plastic, custom
V2627	Scleral cover shell
V2632	Posterior chamber intraocular lens
V2788	Presbyopia correcting function of intraocular lens