



Durable Medical Equipment (DME), Orthosis/Orthotics, Prosthetics and Supplies (DMEPOS) List Effective May 8, 2023

This information is updated regularly. It is not an all-inclusive list of DME, Orthosis/Orthotics, Prosthetics and Supplies items eligible for coverage. Always consult with enrollee's Certificate of Coverage (COC) or Summary Plan Description (SPD) as all DMEPOS are subject to limits and copayment specified by the Plan. To the extent there is any inconsistency between this document and the terms of an enrollee's benefit plan, the terms of the enrollee's benefit plan documents will control. Unless otherwise stated, quantity limits apply per plan year.

The Plan covers eligible medically necessary, provider prescribed durable medical equipment, prosthetics, orthotics and supplies subject to the coverage statements listed in Clinical Policy D004 Durable Medical Equipment, Orthosis/Orthotics, Prosthetics and Supplies.

HCPCS OF NON- COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Abduction and rotation bars	O	Y	Pur	HCPCS: L3140, L3150, L3160, L3170
Q1004 Q1005 V2787 V2788		Accommodative intraocular lens	P	N	N/A	Devices include, but not limited to: CrystaLens, 1CU, Toric Deluxe See also Refractive Lens
A6430-A6436 K0620		Ace (compression) bandages	S	N	N/A	Over-the-counter
E0617		AED - automated external defibrillator (home defibrillator)	D	N	N/A	Over-the-counter Includes, but not limited to: HeartSmart
		AED - automated external defibrillator garment	D	Y	RO	HCPCS: K0606
A4244 A4245		Alcohol/isopropyl (bottle & wipes)	S	N	N/A	Over-the-counter
A9280		Alert/alarm safety devices & related equipment	D/S	N	N/A	Not primarily medical in nature Includes but not limited to: bed exit monitors, fall detection systems, smoke/ carbon monoxide detectors, telephone alert systems
		Amino Acid Based Elemental Formula	S	B	Pur	HCPCS: B4153 and B4161
		Aqueous shunt	P	Y	Pur	

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
	04/21/15	Artificial cornea	P	Y	Pur	HCPCS: L8609, C1818 Also known as keratoprosthesis
		Artificial Larynx, any type	P	Y	Pur	HCPCS: L8500
		Artificial Larynx replacement battery/accessory, any type	S	Y	Pur	HCPCS: L8505
		Automobile/van modification	D	N	N/A	Coverage not eligible to modify home, car, or van
		Back braces	O	Y	Pur	Not eligible if over-the-counter
		BAHA (bone-anchored hearing aid)	D/P	B	Pur	See Clinical Policy Hearing Devices (MP/H006) HCPCS: L8690, L8691, L8693 If the hearing device is not covered, the implantation of electromagnetic bone conduction hearing device in temporal bone (bone anchor) procedure is also not covered.
		Batteries	S	Y	Pur	With initial purchase only. Additional coverage is provided for specialized batteries for covered equipment, including diabetic equipment, infusion pumps, prosthetic devices (including cochlear implants), and wheelchairs. Hearing aid batteries HCPCS: V5266 - If covered, hearing aid batteries may not be dispensed in a quantity that exceeds a 90- day supply at one time. Hearing aid batteries may not be dispensed unless the recipient needs the batteries and requested them.
		Battery chargers	D	Y	Pur	For use with specialized batteries for covered equipment, including those for prosthetic devices, ventilators and wheelchairs

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Bed pans	D	Y	Pur	Covered if bed bound
7/26/17 for new starts: E0265 E0266, E0270, E0296, E0297		Beds - hospital	D	Y	Pur/R	HCPCS: E0250, E0251, E0255, E0256, E0260, E0261, E0290, E0291, E0292, E0293, E0295, E0297, E0301, E0302, E0304, E0328, E0329 Total electric and institutional beds are not the most cost-effective and therefore not covered (see non-covered column) The following beds are non-covered (not primarily medical in nature): Such as, but not limited to, Adjust-A-Sleep Adjustable Bed, adjustable firmness/support mattresses (Select Comfort/Sleep Number), Craftmatic Adjustable bed, Electropedic Adjustable Bed, Simmons Beautyrest Adjustable Bed, visco-elastic or memory foam mattresses (Tempurpedic, Temper-Pedic), waterbed
		Beds, hospital – accessories/equipment	D	Y	Pur/R	If bed is covered, the associated equipment/accessories are eligible
		Benesch Boots	O	B	Pur	HCPCS: L3212, L3213, L3214 Orthopedic footwear
A4246-A4247		Betadine	S	N	N/A	Over-the-counter
		BiPAP /BPAP	D	Y	Pur/R	HCPCS: E0470 appropriate for sleep apnea Quantity limit: allow one every five years
	4/2/15	BiPAP /ASV	D	Y	RO	HCPCS: E0471: non-covered for obstructive sleep apnea (OSA) - can be allowed for central apnea, including complex sleep apnea, or restrictive thoracic disorders or neuromuscular disorders Also known as adaptive servo ventilation (ASV) HCPCS: E0472 covered See respiratory equipment if used as ventilator
A9279		BiPAP supplies	S	Y	Pur	

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Bilirubin (phototherapy) lights & supplies (blanket cradle)	D	Y	RO	HCPCS: E0202 Rental for up to a maximum of seven days
	6/12/12	Biofeedback device	D	B	Pur/R	HCPCS: E0746
A4660, A4663, A4670		Blood pressure monitor/kit (cuff and sphygmomanometer)	D	N	N/A	Over-the-counter
		Books	S	N	N/A	Primarily educational in nature
		Boot, surgical, ambulatory	O	Y	Pur	HCPCS: L3260
		Brace	O	Y	Pur	Not eligible if over-the-counter
		Braille equipment	D	N	N/A	Primarily educational in nature
		Breast prosthesis custom, post mastectomy, molded to patient model	P	Y	N/A	HCPCS: L8035 Post mastectomy only, excludes cosmetic uses. 2 allowed per year per side.
		Breast prosthesis, mastectomy bra	P	Y	Pur	HCPCS: L8000 6 allowed per year; dispense 2 at a time
		Breast prosthesis, mastectomy bra with integrated breast prosthesis form, unilateral or bilateral	P	Y	Pur	HCPCS: L8001(unilateral), L8002 (bilateral) 6 allowed per year – dispense 2 at a time
		Breast prosthesis, mastectomy sleeve	P	Y	Pur	HCPCS: L8010 2 allowed per year
	08/25/16	Breast prosthesis garment, with mastectomy form, post mastectomy	P	Y	Pur	HCPCS: L8015 2 allowed per year
		Breast prosthesis, mastectomy form	P	Y	Pur	HCPCS: L8020 2 allowed per year
		Breast prosthesis, silicone or equal – external (with or with-out integral adhesive)	P	Y	Pur	HCPCS: L8030, L8031 2 allowed per year - per side Post mastectomy only, excludes cosmetic uses. Silicone breast prostheses are expected to last 24 months. For fabric, foam, or fiber-filled breast prostheses the useful life expectancy is 6 months.

PreferredOne®

HCPCS OF NON- COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Breast prosthesis, not otherwise specified, external	P	Y	Pur	HCPCS: L8039 Post mastectomy only, excludes cosmetic uses. 2 allowed per year per side
		Breast pump (manual)	D	Y	Pur	HCPCS: E0602 Single or double. Must be ordered by a provider Purchase of a manual or standard electric breast pump is limited to one purchase per pregnancy, even in the case of a birth resulting in multiple infants, or at any time following delivery. 1 allowed for each pregnancy
		Breast pump (electric)	D	Y	Pur	HCPCS: E0603 Single or double. Must be ordered by a provider Purchase of a manual or standard electric breast pump is limited to one purchase per pregnancy, even in the case of a birth resulting in multiple infants, or at any time following delivery. 1 allowed for each pregnancy
		Breast pump ("hospital- grade")	D	Y	RO	HCPCS: E0604 Must be ordered by a provider Covered when a newborn remains in the hospital after the mother is discharged up to the maximum rental price of \$500 or the date the infant is discharged, whichever comes first. Covered in addition to a manual or electric breast pump. Eligible for rental, only: up to total price of \$500.

HCPCS OF NON- COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Breast pump supplies	S	Y	Pur	HCPCS: A4281, A4282, A4283, A4284, A4286, K1005 Coverage includes supplies necessary for the operation of a personal-use manual or electric pump, Necessary supplies include: pump tubing, pump adaptor, cap for breast pump bottle, breast-nipple shield/splash protector required for the pump to operate, bottles specific to breast pump operation, locking rings, valves, filters, and bags Does not include, but not limited to, nursing pads Coverage of replacement supplies extends for the duration of breastfeeding
		Camisole, post mastectomy	D	Y	Pur	HCPCS: S8460 One post mastectomy only
		Cane, white for blind	D	N	N/A	Not primarily medical in nature
E0316		Canopy, enclosure frame for use w/ hospital bed	D	N	N/A	Institutional use, only
		Catheters, rectal irrigation	S	Y	Pur	Also known as rectal tube
		Cervical collar	O	Y	Pur	Not eligible for coverage if available over-the-counter
		Cochlear Implant	P	B	Pur	HCPCS: L8614 CPT for implantation 69930 See Clinical Policy Hearing Devices (MP/H006)
		Cochlear implant external speech processor, replacement parts	P/S	B	Pur	HCPCS: L8615, L8616, L8617, L8618, L8619, L8627, L8628, L8629 Benefits must be available for cochlear implants. Covered if cochlear implant no longer functioning due to normal wear and use
		Comfort items	D/S	N	N/A	Not primarily medical in nature

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
E0170, E0171, E0172, E0175		Commode	D	Y	Pur	HCPCS: E0163, E0165, E0167, E0168 Covered if a member with a condition that limits mobility is confined to one room or one level that does not have a bathroom. Commodes with integrated lift mechanism not eligible for coverage, they are not a standard model. Footrest for use with commode chair is considered a convenience item and not primary medical in nature and is excluded
E2500-E2599 L8510		Communication/speech aids/voice amplifier	D/S	B	Pur	Equipment to augment/supplement, create or replace communication abilities is excluded in most plans, including synthesized speech devices with dynamic display, speech generating devices, speech processors, receivers, communication boards, or computer or electronic assisted communication.
		Compression burn garments	D	Y	Pur	Quantity limit: 1 per month for the following HCPCS: A6501, A6502, A6503, A6509, A6510, A6511, A6512, A6513 Quantity limit: 2 per month for the following HCPCS: A6504, A6505, A6506, A6507, A6508

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
A6544		Compression garments (eg, capris, camisoles, sleeves and stockings)	S	Y	Pur	<p>Over-the-counter not eligible Coverage is limited to pre-made (ready-made) or custom-made pressure gradient garments including sleeves and support stockings (eg, Jobst, Sigvaris, Medi Strumpf, Venes, etc.) and require a provider's prescription and measurement of the patient for fitting.</p> <p>The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.</p> <p><u>HCPCS A6530, A6531, A6532, A6533, A6534 A6535 Gradient compression stockings:</u> 16 units per limb per 12 months</p> <p><u>HCPCS A6536, A6537, A6538, A6539, A6540, A6541 Gradient compression stockings full chap or waist lengths:</u> 8 units per 12 months</p> <p><u>HCPCS A6545 Gradient compression wrap:</u> 16 units per limb per 12 months</p> <p><u>HCPCS A6549 Gradient compression stocking/sleeve NOS:</u> 16 units per limb per 12 months</p> <p><u>HCPCS S8420-S8429 Gradient pressure and sleeve/glove:</u> 4 units per affected limb per 12 months</p> <p><u>HCPCS A4600 Sleeve for intermittent limb compression device, replacement:</u> 1 per affected limb per 12-month period</p> <p><u>HCPCS A4490, A4495, A4500, A4510 Surgical stockings:</u> 8 units per limb per 12 months</p>

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Continuous Glucose Monitor Systems	D	Y	Pur/R	See Clinical Policy Continuous Glucose Monitoring Systems (MC/L008) Effective 10/01/2020, CGMS has moved to the Pharmacy benefit for most employer groups If the receiver/monitor is not covered, the supplies are also non-covered. Devices include, but are not limited to, Freestyle Libre, Dexcom, Guardian, and MiniMed Eversense CGMS - see Investigative List (0446T)
		Continuous passive motion device (CPM)	D	Y	RO	HCPCS: E0935, E0936 Rental for up to 30 days per /limb post-operative for surgery to a joint (eg, total knee replacement/arthrodesis, anterior cruciate ligament (ACL) repair, or contracture release) Can allow up to eight weeks post-operative for autologous chondrocyte implantation (ACI)
		Convenience items	D/S	N	N/A	Not primarily medical in nature Includes, but not limited to: specialty clothes
A4267-A4269		Contraceptive supplies	S	N	N/A	Over-the-counter Not primarily medical in nature
		Cotton applicators (eq, tips, balls, etc.)	S	N	N/A	Over-the-counter Not primarily medical in nature
		Cotton tipped applicators (swabs), sterile	S	Y	Pur	

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		CPAP (continuous positive airway pressure device	D	Y	Pur/R	HCPCS: E0601 Can allow for diagnosis of obstructive sleep apnea, based on a sleep study . Requests for new or replacement devices must be accompanied by recent (within the past 12 months) clinical documentation from the sleep appliance specialist (provider such as provider or dentist). No claims for CPAP and oral device will be paid within the same 12 month period unless documentation submitted by a sleep provider supports that the member requires both due to failure of PAP alone. Replacement is allowed every five years, when documentation supports compliance with therapy. See Clinical Policy Obstructive Sleep Apnea, Non-surgical Treatment (MC/C011)
A9279		CPAP accessories/ supplies /humidifiers	S	Y	Pur	Water itself is not covered Water or waterless humidifiers are covered
		Cranial Remolding Orthosis	O	Y	Pur	HCPCS: S1040 – also known as CranioCap
		Diabetic equipment/ supplies	D/S	Y	Pur	Blood glucose monitors, blood glucose test strips, lancets, urine test strips May also be covered under the prescription drug benefit
	4/10/13	Diabetic shoes	O	B	Pur	Over-the-counter items not covered HCPCS A5500, A5501 Allow two pair per year. Can be dispensed at same or separate times
	3/5/15	Diabetic shoe inserts	S	B	Pur	Over-the-counter items not covered HCPCS: A5512, A5513, A5514 Allow up to four/foot/year
		Dietary formulas	S	B	Pur	HCPCS: B4153, B4157, B4161, B4162 if taken orally. If given via G/J tube, see enteral therapy.

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Diathermy units	D	N	N/A	HCPCS: K1004 Not appropriate for home use (eg, ultrasound devices; or short-wave diathermy devices; or microwave diathermy devices)
		Disposable items	D/S	N	N/A	
		Drug delivery devices	S	Y	Pur	Covered when used to deliver prescription medications Includes, but not limited to: needles/syringes, intranasal mucosal atomization devices, Aero chambers for use with inhalers
		Drionic devices	D	Y	Pur/R	Also known as iontophoresis
		Duplicate/similar items	D/S	N	N/A	Such as, but not limited to, travel CPAPs or travel nebulizers
		Ear plugs/molds/ear popper	S	N	N/A	Over-the-counter Not primarily medical in nature Includes, but not limited to: Otovent
		Educational items	D/S	N	N/A	
		Electrical nerve stimulators, transcutaneous or percutaneous	D	Y	Pur	HCPCS: E0720, E0730 Eligible for chronic pain only, must have failed conservative treatment. Also known as TENS or PENS . Not covered for acute conditions. Eligible for chronic conditions; only after failure conservative treatment. Allow one every three years

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Electrical nerve stimulator supplies	S	Y	Pur	HCPCS: A4595 Covered for recipients using medically necessary TENS units. Includes all supplies necessary for use of the TENS unit for one month, including adhesive, adhesive remover, batteries, conductive paste or gel and electrodes. Not to be billed with A4556, A4558, A4630 One unit per month covered for 2 lead TENS, two units covered per month for 4 lead TENS.
	07/03/19	Electrical salivary reflex stimulator (intra-oral/ non-invasive)	D	Y	Pur	HCPCS: E0755
	06/22/16	Electrical stimulation, sacral anterior nerve roots	D	Y	Pur/R	HCPCS: E0745, L8681, L8682, L8684, L8685, L8686, L8687, L8688 by means of an implanted stimulator, the Vocare Bladder System
	2/17/14	Electrical stimulation used for cancer treatment	D	Y	RO	HCPCS: E0766, A4555 transducer Also known as NovoTTF-100L system, Optune, alternating electric field therapy, electric tumor treatment fields (TTFields). Medically necessary for malignant neoplasm of brain (supratentorial glioblastomas [WHO grade IV astrocytomas]); ICD-10 diagnosis codes C71.0 - C71.9
		Emesis basin	S	N	N/A	Convenience item
		Enemas	S	N	N/A	Over-the-counter

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
	07/10/18	Enema system, manual pump-operated	S	Y	Pur	HCPCS: A4459 Allow quantity of 1 enema kit/6 months (total 2/year) HCPCS: A4453 Allow quantity of 6 sets/3 months rectal irrigation catheters (15 catheters/set - total 24 sets/year) Includes, but not limited to: Peristeen anal pump, rectal irrigation, trans-anal irrigation. Medically necessary for the management of chronic neurogenic bowel when initial management involving diet, bowel habit, laxatives or constipating medications has failed.
		Enteral therapy	D/S	B	P	Enteral nutrition via tube is considered medically necessary for individuals when the enteral nutrition comprises most of the diet, and the product is used under the supervision of a provider or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and nutrients cannot be taken orally due to a medical condition which either: Interferes with swallowing (eg, dysphagia from a neurological condition, severe chronic anorexia nervosa unable to maintain weight and nutritional status with oral nutrition); or Is associated with obstruction of the proximal gastrointestinal tract (eg, tumor of the esophagus).
		Enteral feeding supplies	S	B	Pur	HCPCS: Q9994, B4105 Pump, tubing In-line cartridge – digestive enzyme for enteral feeding (RELIZORB)

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
E0605		Environmental control	D	N	N/A	Not primarily medical in nature Includes, but not limited to, air conditioner, air filter, air purifier, allergy free materials (eg, pillows, mattress, etc.), cooling vest, electrostatic machine, fan, humidifier, vaporizer, water filter
		Erectile vacuum device-external	D	B	Pur	HCPCS: L7900 Also known as vacuum constriction device Includes, but not limited to: Rejoyn and Osbon
K1007	06/2021	Exoskeleton suit, lower body – robotic	D	N	N/A	See Investigative List Includes, but not limited to: ReWalk
A9300		Exercise equipment	D	N	N/A	Not primarily medical in nature Includes, but not limited to: bicycles, exercise cycles, inversion chair/table, jump ropes, skis, trampolines, weights/system
		External Breast Prosthesis Garment, with Mastectomy form, Post Mastectomy	P	Y	Pur	HCPCS: L8015 Covered for use in the postoperative period prior to permanent breast prosthesis or as an alternative to mastectomy bra and breast prosthesis. 2 allowed post mastectomy only
		Eye patches	S	N	N/A	Over-the-counter
		Food products, special dietary for PKU and other inborn errors of metabolism	S	B	Pur	HCPCS: S9433, S9434, S9435
B4100		Food thickener	S	N	N/A	Over-the-counter
		Foot, Arch supports, removable/non-Removable	O	B	Pur	
		Footboard	D	N	N/A	Over-the-counter Not primarily medical in nature
	9/25/13	Formula, infant	S	N	N/A	Routine infant formula is non-covered when consumed orally

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Formula, PKU or Amino Acid Elemental Based	S	B	Pur	PKU formula HCPCS: B4157, B4162 Amino Acid Based Elemental formula HCPCS: B4153, B4161
		Functional electrical stimulator (FES); transcutaneous stimulation of nerve and/or muscle groups, any type, complete system	D	Y	Pur/R	<p>HCPCS: E0770</p> <p>Medically necessary to enable members with spinal cord injury (SCI) to ambulate when all the following criteria are met:</p> <ul style="list-style-type: none"> • Member has intact lower motor units (L1 and below) (both muscle and peripheral nerve); and • Member has joint stability to bear weight on upper and lower extremities, and has balance and control to maintain an upright posture independently; and • Member demonstrated brisk muscle contraction to neuromuscular electrical stimulation and has sensory perception of electrical stimulation sufficient for muscle contraction; and • Member has the cognitive ability to use such devices for walking and is highly motivated to use the device long term; and • Member can transfer independently and stand for at least 3 minutes; and • Member possesses hand and finger function to manipulate the controls; and • Member is at least 6 months post recovery of spinal cord injury and restorative surgery; and • Member does not have hip and knee degenerative disease and has no history of long bone fracture secondary to osteoporosis; and • The member has successfully completed a training program, which consists of at least 32 physical therapy sessions with the device over a 3-month period. <p>Parastep I System is specifically contraindicated and has no proven value for members with SCI with any of the following:</p> <ul style="list-style-type: none"> • Members with cardiac pacemakers; or • Members with severe scoliosis or severe osteoporosis; or • Members with skin disease or cancer at area of stimulation; or • Members with irreversible contracture; or • Members with autonomic dysreflexia. <p>See Investigative List for other uses</p> <p>FES exercise devices such as the FES Power Trainer, ERGYS, REGYS, NeuroEDUCATOR, STimMaster Galaxy, RT200 Elliptical, RT300 FES Cycle Ergometer (also referred to as a FES bicycle), RT600 Step and Stand Rehabilitation Therapy System, and SpectraSTIM are considered exercise equipment and are excluded from coverage</p>

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Functional neuromuscular stimulator, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training	D	Y	Pur/R	HCPCS: E0764 Can allow when used with Parastep I System (see above) See Investigative List for other uses
	7/15/15	Gel sheeting	S	N	N/A	Over-the-counter Not primarily medical in nature Also known as GelShapes
		Gloves (rubber, latex)	S	N	N/A	Over-the-counter Not primarily medical in nature
S8265	04/29/16	Haberman Feeder	D	N	N/A	Over-the-counter Not primarily medical in nature Also known as cleft lip/palate bottle
	8/2/15	Head support	S	N	N/A	Over-the-counter Not primarily medical in nature Includes, but not limited to: hensinger collar
		Hearing aids	D	B	Pur	See Clinical Policy Hearing Devices (MP/H006)
	8/7/12	Hearing aid accessories	D	B	Pur	HCPCS: V5267 Hearing aid accessories such as chest harnesses, telecoils, and tone and ear hooks are covered when not included in the price of the hearing aid. Telecoils are covered if not standard with recommended hearing aid in the following circumstances: One aid per person, when the audiologist determines a recipient needs the telecoil to use the telephone and after the audiologist determines the recipient's telephone is compatible with the hearing aid's telecoil by report or direct examination

PreferredOne®

HCPCS OF NON- COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
E0200, E0205, E0210, E0215, E0217, E0218, E0236, E0249		Heat/cold application heat/cold circulation device	D/S	N	N/A	Convenience item Over-the-counter Includes, but not limited to: aqua K pad, cold therapy, heat lamp, heating pad, ice pack
		Helmets	D	Y	Pur	HCPCS: A8000, A8001, A8002, A8003 prefabricated or custom fabricated covered for members at risk of head injury due to medical condition such as seizures, developmental disability, post-operative craniotomy or plagiocephaly. Limit of 1 per year for age 2 and older. Under age 2 may need more frequent replacements (up to 1 per every 3 months). HCPCS: A8004 covered if original helmet covered

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
	1/1/21 Revised	High-frequency chest wall oscillation air-pulse generator or system (vest)	D	Y	Pur/R	<p>HCPCS: E0483 Covered for the following:</p> <ul style="list-style-type: none"> • Bronchiectasis, confirmed by CT scan, characterized by daily productive cough for at least 6 continuous months or by frequent (i.e., more than 2 times/year) exacerbations requiring antibiotic therapy; or • Cystic fibrosis or immotile cilia syndrome; or • One of the following neuromuscular disease diagnoses: <ul style="list-style-type: none"> ➢ Acid maltase deficiency ➢ Anterior horn cell diseases, including amyotrophic lateral sclerosis ➢ Hereditary muscular dystrophy ➢ Multiple sclerosis ➢ Myotonic disorders ➢ Other myopathies ➢ Paralysis of the diaphragm ➢ Post-polio ➢ Quadriplegia regardless of underlying etiology. • Lung transplant recipients, within the first 6 months post-operatively, who are unable to tolerate standard chest physiotherapy. <p>Also known as The Vest, ThAIRapy Vest, Airway Clearance System Vest, InCourage, SmartVest, Bronchial drainage vest</p> <p>HCPCS: A7025, A7026 covered if original system covered</p>

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
E0160 E0161 E0162 E0240 E0241 E0242 E0243 E0244 E0245 E0246 E0247 E0248 E0273 E0274 E1300 E1310		Household equipment/ fixtures	D	N	N/A	Not primarily medical in nature Includes, but not limited to: bath aids/equipment (bath/shower chair, rail, bar, bench, mat, lifts), bed boards, bed sheets, birthing tub, grab bars, hand-held shower, hot tub, over-the bed\wheelchair table, leg rest (foot stool), raised toilet seat, reaching aids, sauna, sitz bath, swimming pool, whirlpool tub
		Household modification	D	N	N/A	Coverage not eligible to modify home or car environment to meet needs of member/ caregiver this includes equipment, fixtures and modifications to the structure of the home. Includes, but not limited to: elevator, escalator, Independence iBot 3000 Mobility System, ramps, stair rail, stair lift guide
		Hydrogen peroxide	S	N	N/A	Over-the-counter
		Hygiene items	D/S	N	N/A	Convenience items Over-the-counter Not primarily medical in nature
		Immobilizer (eg, shoulder, arm, knee ankle)	O	Y	Pur	Not covered if over-the-counter
A4336, A4337, A4554, A4520, T4521, T4542		Incontinence supplies	S	N	N/A	Convenience items Over-the-counter Not primarily medical in nature Includes, but not limited to: chux, diapers, FemSoft inserts
		Incontinence warning devices	D	N	N/A	Over-the-counter Not primarily medical in nature Includes, but not limited to: bed wetting alarm

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
S8301	05/13/23	Infection control supplies	S	N	N/A	
A4639, E0221		Infrared Heating Pad (Monochromatic Infrared Therapy)	D	N	N/A	See Investigative List
		Infusion pumps/ accessories	D	Y	R	
		INR / Prothrombin Time Testing Devices / Monitor	D	Y	Pur	HCPCS: G0248, G0249, G0250 Covered for long term anticoagulant use due to prosthetic cardiac valve, recurrent DVT, PE or atrial fibrillation/ flutter. Devices include, but not limited to: INRatio, CoaguCheck, ProTime
		INR / Prothrombin Time Testing Device supplies/ test strips	S	Y	P	
		Insulin infusion pump	D	Y	Pur/R	See Clinical Policy Insulin Infusion Pumps (MC/L011) If the pump is not covered, the supplies are also non-covered. Devices include, but are not limited to: Animas, MiniMed, OmniPod, Tandem, V-Go
	06/02/14	Intraperitoneal/ intra-peritoneal nutrition or amino acid supplementation	S	Y	Pur	
		IPPB machines	D	Y	R	
		Iontophoresis home device	D	Y	Pur/R	Also known as drionic device
	11/22/13	Jaw motion rehabilitation system	D	Y	P/R	HCPCS: E1700 Is medically necessary to treat mandibular hypomobility caused by radiation in persons with head and neck cancers. Devices include, but not limited to, Therabite Jaw Motion Rehabilitation System
		Leg brace	D	Y	Pur	
E0639 E0640		Lifts, patient	D	Y	Pur/R	HCPCS: E0625, E0630, E0635, E0636 HCPCS for supply: E0621

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Lubricant	S	N	N/A	Over-the-counter Includes, but not limited to: K-Y jelly
		Maternity support belt / prenatal cradle	D	N	N/A	Over-the-counter Not primarily medical in nature Includes, but not limited to: Mother-To-Be
		Massage devices	D	N	N/A	Over-the-counter Not primarily medical in nature
		Medication Dispenser/ pill dispenser	S	N	N/A	Over-the-counter Not primarily medical in nature
E1801 E1802 E1806 E1811 E1815 E1816 E1818 E1831 E1840 E1841		Mechanical stretch devices: dynamic splinting devices (aka low-load prolonged stretch [llps] devices); bi-directional static progressive (sp) devices; patient-actuated serial stretch (pass) devices	S	Y	Pur/R/RO/*N/A	Dynamic splinting devices are proven effective/ covered for use on elbow, finger, knee, toe, and wrist. Allow one device per affected part. HCPCS: E1800, E1805, E1810, E1812, E1825, E1830; *Dynamic splinting devices are investigative for use on forearm, ankle, and shoulder - LLPS devices include, but are not limited to Dynasplint, Ultraflex, LMB Pro-glide, EMPI Advance, and SaeboFlex See Investigative List . *SP devices are investigative for all indications. SP devices include, but are not limited to, Joint Active Systems (JAS) splints (eg, JAS Elbow, JAS Shoulder, JAS Ankle, JAS Knee, JAS Wrist, and JAS Pronation-Supination), and Air Cast *PASS devices are investigative for all indications. PASS devices include, but are not limited to, ERMI Knee Extensionater, ERMI Elbow Extensionater, ERMI Knee/Ankle Flexionater, ERMI Shoulder Flexionater, and knee extension devices (eg, Elite Seat)
		MEI (middle ear implantable) hearing aid	D/P	B	Pur	See Clinical Policy Hearing Devices (MP/H006)

PreferredOne®

HCPCS OF NON- COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Mobility equipment	D	Y	Pur/R	See Clinical Policy Wheelchairs and Mobility Assistive Equipment (MC/D003) Includes walkers, canes, crutches, gait trainer, roll-about (knee walker), walkers
		Monitoring equipment	D	Y	RO	Includes, but not limited to: airway pressure monitor, apnea monitor, cardiorespiratory (CR) monitor, memory monitor (apnea & recorder, trend event monitor), pulse oximeter
E0765		Nausea mitigation devices (eg, Relief band)	D	N	N/A	Over-the-counter
		Nebulizer	D	Y	Pur	Can allow one up to every three years
		Nebulizer supplies /accessories (except water)	S	Y	Pur	Can allow if device is allowed
		Needle free injection device or system	D	Y	Pur	HCPCS: A4210 Includes, but not limited to: Advanta Jet, Bioject, Biojector 2000, Freedom Jet, Medi-Jector EZ, Vita-Jet II, Medically necessary when the member or the member's caregiver is physically unable to use a conventional needle-syringe. A jet injector may be appropriate for some individuals with medical conditions that make it impossible for them to use a conventional needle-syringe, such as but not limited to, severe arthritis, severe tremors, or blindness. The use of jet injectors for other reasons is considered non-covered, due to patient convenience.
E0744		Neuromuscular electrical stimulator for scoliosis	D	N	N/A	See Investigative List

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
	06/22/16	Neuromuscular electrical stimulator (NMES) form-fitting conductive garment	D	Y	Pur/R	<p>HCPCS: E0731</p> <p>Medically necessary only when it has been approved for marketing by the FDA, has been prescribed by a provider for use in delivering NMES that is considered medically necessary, and any of the following criteria is met:</p> <ul style="list-style-type: none"> • The member cannot manage without the conductive garment due to the large area or the large number of sites to be stimulated, and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; or • The member has a skin problem or other medical conditions that precludes the application of conventional electrodes, adhesive tapes, and lead wires; or • The member requires electrical stimulation beneath a cast to treat disuse atrophy, where the nerve supply to the muscle is intact; or • The member has a medical need for rehabilitation strengthening following an injury where the nerve supply to the muscle is intact.

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
	3/11/14	Neuromuscular stimulator, electric shock unit	D	Y	Pur/R	HCPCS: E0745 is M/N for disuse atrophy where the nerve supply to the muscle is intact and the member has any of the following non-neurological reasons for disuse atrophy: <ul style="list-style-type: none"> • Contractures due to burn scarring; or • Major knee surgery (when there is failure to respond to physical therapy); or • Previous casting or splinting of a limb; or • Recent hip replacement surgery until physical therapy begins See Investigative List for other indications
	08/25/16	Nipple prosthesis	P	Y	Pur	HCPCS: E8032 Allow 1 prosthesis per side for the useful lifetime of the prosthesis
	01/17/20	Nipple prosthesis, custom	P	Y	Pur	HCPCS: L8033
E0761 G0295 G0329	08/14	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	D	N	N/A	HCPCS: E0761, G0295, G0329 See Investigative List Includes, but not limited to: OrthoCor Active Knee System, Diapulse, Provant Wound Closure System, SofPulse
A4214, A4323		Normal saline	S	N	N/A	Over-the-counter
	1/17	Optical devices/ visual aids for low vision	S	B	N/A	Includes, but not limited to: high power spectacles, miniature magnifiers and telescopes

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Oral appliances / mouth guard /splint (custom fitted)	D	B	Pur	<p>Over-the-counter items not covered HCPCS: D7880, D8210, D9947, E0485, E0486 and K1027 eligible under medical benefit for diagnosis such as, but not limited to, of obstructive sleep apnea/upper airway resistance syndrome, when the diagnoses have been confirmed by a sleep study. See Clinical Policy Obstructive Sleep Apnea, Non-Surgical Treatments (MC/C011)</p> <p>No claims for oral device and PAP will be paid within the same 12 month period unless documentation submitted by a sleep provider supports that the member requires both due to failure of PAP alone. HCPCS: D7880, D8210, D9947, E0485, E0486 and K1027 - Allow one every three years when documentation supports regular follow-up with the ordering provider (within the previous 12 months)</p> <p>Not eligible for the diagnosis of snoring. For TMJ diagnosis, see Temporal Mandibular Joint entry. Check dental benefits for coverage regarding requests for teeth grinding/bruxism, in absence of an associated medical diagnosis.</p>
		Orthopedic Footwear (shoes)	O	B	Pur	<p>Only custom fitted/molded are covered. Over-the-counter items not covered HCPCS: L3201, L3202, L3203, L3204, L3206, L3207, L3215, L3216, L3217, L3219, L3221, L3222, L3230, L3250 Allow two pair per year</p>

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Orthopedic Footwear used as an integral part of a brace	O	Y	Pur	Only custom fitted/molded are covered. Over-the-counter items not covered HCPCS: L3224, L3225 Allow two pair per year, even if the brace is on one leg
		Orthopedic Shoe Additions	O	B	Pur	Only custom fitted/molded are covered. Over-the-counter items not covered HCPCS: L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595
		Orthopedic Shoe Heels	O	B	Pur	Only custom fitted/molded are covered Over-the-counter items not covered HCPCS: L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420
		Orthopedic Shoe Inserts (orthotics)	O	B	Pur	Only custom fitted/molded are covered. Over-the-counter items not covered HCPCS: L3000, L3001, L3002, L3003, L3010, L3020, L3030, L3031 Includes Berkeley Shell, Spenco, and Plastazote Allow up to 3 per foot per year
		Orthopedic Shoe Lifts	O	B	Pur	Only custom fitted/molded are covered. Over-the-counter items not covered HCPCS: L3300, L3310, L3320, L3330, L3332, L3334 Allow up to 2 per foot per year
		Orthopedic Shoe Wedges	O	B	Pur	Only custom fitted/molded are covered. Over-the-counter items not covered HCPCS: L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420 Allow up to 2 per foot per year
		Orthotic Additions, spinal	O	Y	Pur	HCPCS: L0970, L0972, L0974, L0976, L0978
		Orthotic Devices, Cervical-Thoracic-Lumbar – Sacral (CTL SO)	O	Y	Pur	HCPCS: L0700, L0710

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Orthotic Devices, Fracture Orthoses and additions	O	Y	Pur	Lower limb HCPCS: L2106-L2192 Upper limb HCPCS: L3980, L3995
		Orthotic Devices, HALO and additions	O	Y	Pur	HCPCS: L0810, L0820, L0830, L0859, L0861
		Orthotic Devices, Lower Limb; Hip				HCPCS: L1600-L1755, L2040-L2090 Allow one per year
		Orthotic Devices, Lower Limb Hip Flexible, Legg Perthes, Knee, Ankle-Foot, Hip-Knee-Ankle-Foot, Torsion Control, Ankle-Foot, Hip-Knee-Ankle-Foot	O	Y	Pur	HCPCS: L1810-L2037, L2106-L2999, L4350-L4631 Allow up to 2 per extremity per year
L2006		Orthotic Device, Lower Limb Knee ankle foot device, any material, single or double upright, swing and/or stance control with adjustability, includes all components, any type activation, with or without ankle joint(s), custom fabricated	N/A	N	N/A	See Investigative List
		Orthotic Devices, Sacroiliac - Lumbar - Sacral (LO, LSO, SLO, SLSO)	O	Y	Pur	HCPCS: L0621- L0651
		Orthotic Devices, Scoliosis Procedures (CTL SO) and additions	O	Y	Pur	HCPCS: L1000-L1120
		Orthotic Devices, Scoliosis Procedures Thoracic-Lumbar-Sacral (TLSO) and additions	O	Y	Pur	HCPCS: L1200- L1290
		Orthotic Devices, Scoliosis Procedures, Other	O	Y	Pur	HCPCS: L1300, L1310

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Orthotic Devices, Spinal, Cervical	O	Y	Pur	HCPCS: L0112, L0113, L0120, L0130, L0140, L0150, L0160, L0170, L0127, L0174, L0180, L0190, L0200
		Orthotic Devices, Thoracic-Lumbar- Sacral (TLSO)	O	Y	Pur	HCPCS: L0450- L0492
		Orthotic Devices, Upper Limb and additions	O	Y	Pur	SO, EO, EWHO, EWHFO, FO, HFO, SEWHO, WHFO, WHO HCPCS: L3650-L3999 Allow up to 2 per extremity per year
		Orthotic Services, ancillary	O	Y	Pur	HCPCS: L4350-L4631
L0980, L0982, L0984	07/10/18	Orthotic additions, spinal	S	N	N/A	
		Osteogenesis stimulator	D	Y	Pur/R	See Clinical Policy Bone Growth Stimulators (MC/F021) HCPCS: E0747, E0748, E0749, E0760
		Ostomy supplies	S	Y	Pur	Colostomy, gastrostomy, ileostomy, jejunostomy, urostomy
		Oxygen contents	S	Y	Pur	
		Oxygen equipment	D	Y	RO*	* Rental only Includes oxygen/gaseous/liquid systems, concentrator, container, flow meter, humidifier, nebulizer, oxygen, water, regulator, oxygen tent
A4265, E0235		Paraffin Bath (portable or standard, supplies)	D	N	N/A	Institutional, not appropriate for home use
		Peak flow meters	D	Y	Pur	
		Parental pump	D	Y	R	
		Parental solution	S	Y	Pur	
		Parental solution administration supplies	S	Y	Pur	
	11/18/11	Pelvic Floor Stimulator, incontinence treatment system (monitor, sensor, and/or trainer)	D	Y	Pur/R	HCPCS: E0740 Not considered biofeedback

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Penile Implant, inflatable or non-inflatable	P	B	Pur	Includes, but not limited to: inflatable - AMS700CXM, Mentor Alpha 1; non-inflatable – AMS Maleable, Mentor Genesis
		PENS	D	B	R	Eligible for chronic pain only, after failure of conservative treatment
E0481		Percussive, ventilation systems intrapulmonary	D	N	Pur	HCPCS: E0481 Not routinely covered
	04/01/10	Personal Therapy Manager (PTM)	D	Y	Pur	Used in conjunction with an implantable pain pump
		Pessary	D	Y	Pur	
		Physical therapy equipment	D	N	N/A	Not eligible for purchase or rental for home use. Includes, but not limited to: back extension machine (Roman Chair), Cybex Back System, parallel bars, ROMTech PortableConnect Adaptive Telemed
E0943		Pillows (head, lumbar/cervical)	D	N	N/A	Over-the-counter Not primarily medical in nature
		Pleoptic training aids	D	N	N/A	
	Updated 07/26/17	Pneumatic appliances/garments	D	Y	Pur/R	HCPCS: E0655, E0656, E0657, E0660, E0665, E0666, E0667, E0668, E0669, E0670 E0671, E0672, E0673
		Pneumatic compression devices	D	Y	Pur/R	See Clinical Policy DMEPOS, Pneumatic Compression Devices (MC/D006) HCPCS: E0650, E0651, E0652
		Pneumatic compression device, high pressure	D	Y	R	See Clinical Policy DMEPOS, Pneumatic Compression Devices (MC/D006) HCPCS: E0675
E0190	Updated 03/03/22	Positioning cushion/pillow/wedge	S	N	N/A	Over-the-counter Not primarily medical in nature Includes, but not limited to, Zzoma.
		Postural drainage equipment (board)	D	Y	Pur	

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Power operated vehicles	D	Y	Pur/R	See Clinical Policy DMEPOS, Wheelchairs and Mobility Assistive Equipment (MC/D003)
E0183		Pressure reducing surfaces	D	Y	Pur/R	HCPCS: E0181- E0189 and E0193-E0199 Includes, but not limited to: alternating pressure pad, dry pressure mattress, gel/gel like mattress overlay, air pressure mattress, water pressure mattress, synthetic sheepskin pad, positioning cushion/ pillow/ wedge, powered air flotation bed, air fluidized bed, gel pressure mattress, air pressure pad, water pressure pad, dry pressure pad (egg crate) E0183 Powered pressure reducing underlay/pad, alternating, with pump is excluded as non-standard E0191 heel/elbow protector allowed for IP, only
	4/27/11	Prosthesis, auricular (ear)	P	Y	Pur	HCPCS: L8045 Medically necessary when there is a loss or absence of ear due to disease, trauma, surgery, or congenital defect, regardless of whether the prosthesis restores function. Does not include the EarWell Correction System Allow replacement every three years
		Prosthesis, eye	P	Y	Pur	
		Prosthesis, face	P	Y	Pur	
L5990		Prosthesis, lower limb	P	Y	Pur	
		Prosthesis, upper limb	P	Y	Pur	
		Protonics Neuromuscular Repositioning System	D	N	N/A	No proven benefit over standard braces
E2120	07/02/12	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	D	N	N/A	See Investigative List Transtympanic Micropressure Device Includes, but not limited to: Meniett device

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Pulse tachometer	D	N	N/A	Not necessary for monitoring pulse
		Rebound tonometry	D	Y	Pur	Also known as ICare
		Recreational equipment	D	N	N/A	Not primarily medical in nature
	07/03/19	Rectal control system	S	Y	P	HCPCS: A4563 Includes, but not limited to: Eclipse Vaginal Insert System
V2100-V2599		Refractive lenses	D	B	Pur	Eyeglasses are not eligible as they generally are excluded in the medical plan document. Contact lenses are typically eligible for coverage when prescribed as medically necessary for the treatment of keratoconus and post-operative treatment of cataracts. Note: Eyeglasses and contacts are not eligible for coverage following cataract surgery if an intra-ocular lens has been placed. Eyeglasses (lens only) or contacts would only be considered a medically necessary post-operative treatment for cataracts if no other lens is present.
		Repair, replacement, revision of eligible DMEPOS item	D	Y	Pur/R	See Clinical Policy Durable Medical Equipment, Prosthetics, Orthotics and Supplies (MP/D004)
	10/03/13	Replacement bulbs	S	B	Pur	HCPCS: A4634 SAD light – replacement bulb HCPCS: A4633 UV light therapy – replacement bulb Eligible if SAD light or UV light equipment is a covered item
	07/03/19	Replacement supplies	S	B	Pur	Replacement of supplies that are not dispensed at time of initial purchase

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
A9279		Respiratory equipment	D	Y	RO*(FOR ventilators) R (for all other devices)	<p>* Ventilators - Rental only. With rental only for respiratory equipment vendor assumes responsibility and liability for duplicates, maintenance, servicing, replacement and supplies necessary for the safety and operation of the item (e.g. breathing circuit, filters, PEEP valve, sterile water, tubing, heated wire circuit, water trap, water chamber, etc.)</p> <p>A second invasive or non-invasive ventilator (stationary or portable [includes BiPAP/ASV and ventilator, multi-function) is M/N for the following (not all inclusive):</p> <ul style="list-style-type: none"> -An individual requires one type of ventilator (eg, a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g., positive pressure ventilator with a nasal mask) during the rest of the day. -An individual who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without both pieces of equipment, the individual may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical Cough stimulating devices, oscillatory positive expiratory pressure device equipment effectively. <p>HCPCS: E0465, E0466</p> <p>HCPCS: E0467 Multi-function ventilator Combines four separate technologies</p> <ul style="list-style-type: none"> • Oxygen concentrator • Cough stimulator • Suction pump • Nebulizer <p>Can allow if meets M/N for all four components</p> <p>HCPCS: E0471, E0472 - See BiPAP/ASV entry</p> <p>Other devices HCPCS: E0482 Cough stimulating devices HCPCS: E0480 Percussor, electric or pneumatic for home use</p> <p>End Tidal Carbon Dioxide Monitor (for use with ventilators), oscillatory positive expiratory pressure device, suction device</p>

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Respiratory masks	S	N	N/A	Over-the-counter Includes, but not limited to: dust or surgical masks
		Respiratory supplies	S	Y	Pur	Other supplies not considered part of standard supplies needed for safety or operation such as humidifiers
A4572		Rib belt	S	N	N/A	Over-the-counter
E0700 E0701 E0710		Safety equipment	D	N	N/A	Not primarily medical in nature Includes, but not limited to: adaptive full-length side safety rail (SleepSafe) beds, manual or electric safety bed systems (eg, KayserBetten Secure Sleep Systems), bed exit monitors (bed alarms), bed rails, belts, car seats (eg, Carrie Car Seat, Columbia Orthopedic Positioning Seat, Gorilla Postural Seat, Snug Seat, Traveller Plus, Special Tomato MPS Car Seat), carbon monoxide detector, fall detection systems, fire extinguishers, first aid kits, grab bars, harnesses, helmets (eg, Danmar soft shell helmet), knee and elbow pads, restraints, safety goggles, service dogs, smoke detectors, telephone alert/warning systems, vehicular restraint systems (eg, EZ-On Vest), automatic external defibrillators for home use
		Scales	D	N	N/A	Over-the-counter Not primarily medical in nature
		Sclera cover shell	S	Y	Pur	HCPCS: V2627 Covered if member has ocular prosthesis; or treatment of keratoconjunctivitis sicca or "dry eye"; or when prescribed to support orbital tissue (such as where an eye has been rendered sightless and shrunken by inflammatory disease)

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Seat lift /mechanism	D	Y	Pur	HCPCS: E0627, E0629 Mechanism eligible only – not the household furniture or integrated systems
	11/20/13	Sensory stimulation tools, such as but not limited to, brushes or oral motor tools	S	N	N/A	Over-the-counter Not medical in nature
		Sheets	S	N	N/A	Over-the-counter Not medical in nature
		Shower/commode combination chair	D	N	N/A	Convenience item Over-the-counter Not primarily medical in nature
		Shoe-horn aid	D	N	N/A	Convenience item Over-the-counter Not primarily medical in nature
		SI Back Support	O	Y	Pur	Over-the-counter
		Sliding board/transfer board	D	Y	Pur	
		Speech teaching machine	D	N	N/A	Communication and educational item Not primarily medical in nature
		Splints	O	Y	Pur	Not eligible if over the counter
		Standing frame/standers	D	Y	Pur	See Clinical Policy DMEPOS, Standing Systems and Gait Trainers (MC/D007) HCPCS: E0637, E0638, E0641, E0642
A4216 A4217 A7018		Sterile water	S	N	N/A	Over-the-counter Includes distilled water
		Stethoscope	D	N	N/A	Over-the-counter
		Strollers	D	N	R	Over-the-counter Not primarily medical in nature
		Sully Shoulder Stabilizer	S	Y	Pur	Over-the-counter
		Support hose	S	N	N/A	Over-the-counter
		Support stockings-custom fitted only	S	Y	Pur	Allow two pair
		Surgical Boot	O	Y	Pur	

PreferredOne®

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
A4450 A4452		Tape	S	N	N/A	Over-the-counter
		Temporal Mandibular Joint (TMJ) appliance/splint/ mouth guard	D	B	Pur	HCPCS: D7880, D8210 Check dental benefits for coverage regarding requests for teeth grinding/bruxism, in absence of an associated medical diagnosis. Allow one every three years
		Tennis elbow band	S	N	R	Over-the-counter
	03/12/15	Testicular prosthesis	P	Y	Pur	Medically necessary for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery.
		Therapeutic light box	D	Y	Pur	HCPCS: E0203 May also be referred to as seasonal affective disorder(SAD) light box Coverage is not provided for devices such as head-mounted units and visors, or for accessory items, such as carrying cases. HCPCS: A4634 SAD light – replacement bulb is covered if the SAD light is a covered item
A4931 A4932		Thermometers-basal, oral, rectal, ear	D	N	N/A	Over-the-counter
		Thoracic Rib Belt	O	Y	Pur	
		Toothettes	S	N	Pur	Convenience item Over-the-counter Not primarily medical in nature
A4575 E0446	12/06/11	Topical hyperbaric oxygen chamber	D	N	N/A	See Investigative List - also known as low dose tissue oxygenation, OxyBox, and TransCu O ₂
		Total Parenteral Nutrition	S	B	Pur	
		Tracheo-esophageal voice prosthesis	P	Y	Pur	HCPCS: L8507, L8509

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Tracheoesophageal voice prosthesis gelatin capsules/equivalent, insert or puncture dilator, replacement	S	Y	Pur	HCPCS: L8511, L8512, L8514, L8515
		Tracheoesophageal supplies	S	Y	Pur	HCPCS: L8513
		Tracheotomy care supplies	S	Y	Pur	
		Tracheostomy speaking valve	D	Y	Pur	HCPCS: L8501
E0941		Traction Equipment	D	Y	Pur/R	
		Trusses	D	Y	Pur	
		Tumble Seat	D	N	Pur	Not primarily medical in nature Also known as feeding seats
E0694		Ultraviolet light therapy devices (eg UVA, UVB; broad and narrow band)	D	Y	Pur/R	HCPCS: E0691, E0692, E0693 Covered for refractory skin conditions such as atopic dermatitis, eczema, lichenification, pruritus of hepatic disease/renal failure, psoriasis, T-cell lymphoma (CTCL)/mycosis fungoides, and vitiligo, that have responded to UV light treatment in the office setting and will need therapy at least 3 times /week. May also be referred to as light box. HCPCS: A4633 UV light therapy – replacement bulb covered if the UV light therapy is a covered item
		Urinals	D	Y	Pur	Covered if bed bound

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
		Urological supplies	S	Y	Pur	HCPCS: A4351, A4352, A4353 Urinary catheters Quantity limit: for intermittent urinary catheters, allow 200/month. Can allow up to 300/month without insertion supplies if requires more than six episodes of catheterization per day Does not include supplies for treatment of incontinence HCPCS: K1006 Suction pump, home model, portable or stationary, any type of use with external urine management system, eg. PureWick Urine Collection System and supplies
	04/01/14	Vaginal dilator	D	Y	Pur	Covered when ordered as part of a physical therapy or provider directed treatment program
	05/03/11	Ventricular assist device supplies	S	Y	Pur/R	HCPCS: Q0477- Q0509 Battery replacement is covered every 6 months; accessory replacement is covered once per year
S9090		Vertebral axial spinal distraction therapy, mechanized (traction decompression)	D	N	N/A	See Investigative List Devices include, but are not limited to: Accu-Spina System IDD, DRX2000, DRX3000, DRX5000, DRX9000, Lordex, SpineMED, SpineRX LDM, Tru Tac 401, and VAX-D. Also known as Vertebral Axial Decompression
	07/15/10	Vitrectomy chair/ vitrectomy table/ vitrectomy support system/ face -down support system	D	Y	R	
	02/17/14	Warranty extended on DMEPOS items	N/A	N	N/A	Non-covered, not medically necessary. Also known as insurance

HCPCS OF NON-COVERED ITEMS	DATE ADDED TO LIST	DESCRIPTION	DME (D) SUPPLY (S) ORTHOSIS/ ORTHOTIC (O) PROSTHETIC (P)	ELIGIBLE YES (Y) NO (N) PER BENEFIT (B)	PURCHASE (PUR) RENT TO PURCHASE (R) RENTAL ONLY (RO)*	HCPCS AND COMMENTS
	11/20/13	Weighted bedding and garments, such as but not limited to, blankets or vests	S	N	N/A	Over-the-counter Not primarily medical in nature
		Wheelchair	D	Y	Pur/R	See Clinical Policy Wheelchairs and Mobility Assistive Equipment (MC/D003)
		Wheelchair accessories	D	Y	Pur/R	See Clinical Policy Wheelchairs and Mobility Assistive Equipment (MC/D003)
		Wheelchair alternative	D	Y	Pur/R	See Clinical Policy Wheelchairs and Mobility Assistive Equipment (MC/D003) HCPCS: E1031, E1037, E1038, E1039 Includes, but not limited to: hoveround, rollabout chair/geri chair, scooters, transport chair / transfer system
		Wigs	D	B	Pur	HCPCS: A9282 When covered, coverage is for synthetic hair wigs, only. Human hair wigs excluded as not most cost effective Diagnosis codes for alopecia areata ICD-10 codes L63.2, L63.8, L63.9
E0769		Wound care equipment	D	Y	RO	HCPCS: E2402 Wound vac / negative pressure wound pump and related supplies (HCPCS: A6550, A7000) Electrical stimulation for wounds-inappropriate for home use
		Wound care supplies	S	Y*	Pur	*Those that are ordered by a provider and are provided by a DME provider may be covered. See specific indications outlined in Clinical Policy Dressing Supplies (MP/D008) Primary and secondary supplies for a ventricular assist device (VAD) are covered if the device is approved (see separate entry)

PreferredOne Community Health Plan Nondiscrimination Notice

PreferredOne Community Health Plan ("PCHP") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PCHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PCHP:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PCHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Community Health Plan
PO Box 59052
Minneapolis, MN 55459-0052
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

ໂບດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອຕໍ່ພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው፡ 763.847.4013) .

ဟ်သ့ဟ်သး- နမံကတိ၊ ကညိ ကျိာ်အယံ၊ နမံကျိာ်အတိမၤစၢၤလၢ တလၢာ်ဘျဉ်လၢာ်စၢၤ နီတမံၤဘျဉ်သန့လီၤ. ကိ: 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្បួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013), 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).

PreferredOne Insurance Company Nondiscrimination Notice

PreferredOne Insurance Company ("PIC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PIC:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

បំពេញ: ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ហៅ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያገኙት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (ማስማት ለተሳናቸው: 763.847.4013) .

ဟံသာဝတီ: နမူနာတို့ ကညီ ကျိအသိ, နမူနာ ကျိအတိအကျတို့ တလက်ကွက်လက်စွာ နှိတ်မိသည့်သို့လိ။ ကိ: 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ហៅ 1.800.940.5049 (TTY: 763.847.4013).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).