

Medicare Advantage Medical Policy



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Endovascular Repair of Iliac Artery Bifurcation – Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 07/16/2025

Effective Date: 08/16/2025

Description

This procedure involves inserting a balloon catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The objective of percutaneous transluminal angioplasty (PTA) is to improve the blood flow through the diseased segment of a vessel so that vessel patency is increased, and embolization is decreased. With the development and use of balloon angioplasty for treatment of atherosclerotic and other vascular stenoses, PTA (with and without the placement of a stent) is a widely used technique for dilating lesions of peripheral, renal, and coronary arteries.

Related Medical Coverage Policies

- N/A

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is not fully established, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

The following are applicable for this medical policy:

Clinical review follows guidance provided in the BCBSM Medicare Advantage *Coverage Determination Hierarchy* policy, which may be found at

<https://www.bcbsm.com/providers/mpradmin/> by entering the policy name. After searching the Medicare Coverage Database and other sources of conditions of coverage, it was determined that CMS guidance to determine medical necessity is not fully developed related to one or more of the codes found in this medical policy. BCBSM/BCN internal coverage criteria will only be applied where CMS guidance is silent for a particular code.

Code	Description	NCD/LCD/LCA	Additional Guidance
34717	Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral (List separately in addition to code for primary procedure)	National Coverage Determinations None Local Coverage Determinations None	When the NCDs, LCDs, or LCAs do not have fully established clinical coverage criteria to determine medical necessity for Endovascular Repair- Iliac Artery Bifurcation refer to the BCBSM/BCN policy: <i>Endovascular Repair- Iliac Artery Bifurcation</i> Policy attached below
34718	Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral		

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determinations is based upon place of service. Place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by member place of residence. Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions

Part A and Part B Medicare Administrative Contractor (MAC) Jurisdiction	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC, Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC, Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
07/17/2024	07/17/2024	Medicare Advantage policy established
08/16/2025	07/16/2025	MA policy foundational language updated. Adoption of JUMP policy updates.

Medical Policy



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Joint Medical Policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. When Centers for Medicare and Medicaid (CMS) coverage rules are not fully developed, this medical policy may be used by BCBSM or BCN Medicare Advantage plans 42 CFR § 422.101 (b)(6).

Please reference the appropriate certificate or contract for benefit information. This policy may be updated and is therefore subject to change.

***Current Policy Effective Date: 7/1/25**
(See policy history boxes for previous effective dates)

Title: Endovascular Repair of Iliac Artery Bifurcation

Description/Background

When the iliac artery is compromised vascularly as a result of a trauma, an aneurysm or infection, immediate repair is often necessary. The standard treatment for common iliac artery aneurysms and injuries is resection of the diseased segment with open graft repair; for internal iliac artery aneurysms, ligation (tying) with or without graft placement is the standard of care.

The iliac arteries are large blood vessels that branch off distally from the aorta, the largest of the body's blood vessels. The right and left common iliac arteries originate at the bifurcation (branching) of the abdominal aorta, and each of the common iliac arteries bifurcates further into the internal and external iliac arteries. These paired vessels supply blood to the pelvis and lower extremities.

An aneurysm is a bulging and weakness in the wall of an artery. The weakened area forms a sac or small balloon that fills with blood. Iliac artery aneurysms can develop as a result of atherosclerosis (hardening of the arteries), infection, trauma or connective tissue disorders such as Marfan syndrome and Ehlers-Danlos syndrome. Involvement of the iliac arteries occurs in 10-20% of patients with abdominal aortic aneurysms (AAAs). An iliac artery aneurysm can progressively expand and spontaneously burst, resulting in life-threatening uncontrolled bleeding.

The purpose of the endoprosthesis, or iliac bifurcation device (IBD), is to reinforce the weakened section of the blood vessel, to prevent rupture of the aneurysm and to maintain adequate blood flow through the vessel. Additionally, the frame of the IBD expands like a spring to press securely against the wall of the artery, cutting off the blood supply to the aneurysm. The blood bypasses the aneurysm and flows through the IBD instead.

The IBD, a flexible hollow tube comprised of synthetic materials, is contained inside a tiny catheter. Using a guide wire, the catheter is introduced into the common femoral artery under fluoroscopic guidance and advanced to the area of repair within the common iliac artery. Once the IBD is in place, it is deployed within the common iliac artery at the aneurysm site, where it expands and adheres to the artery wall. The proximal end of the stent opens to the common iliac artery and the distal end opens and extends into the external iliac artery.

The body of the main IBD contains a branched opening to which an extension IBD is connected. The extension IBD is introduced via a second catheter through the femoral artery and advanced until it reaches the inside of the stationary main IBD. Once inside the lumen of the main IBD, the catheter containing the extension device is threaded through the branched opening and downward into the internal iliac artery, where it expands and remains stationary against the vessel wall. Once connected, the main IBD and the extension IBD form an “upside-down” Y-shaped device that extends from the common iliac artery into the external and internal iliac arteries.

Regulatory Status

The FDA has approved bifurcated devices indicated for endovascular repair of abdominal aortic aneurysm repair with extension grafts to the common iliac arteries, but these devices are not indicated for aneurysms isolated to the common iliac arteries that extend to the internal and external iliac artery branches.

The FDA (2016) approved the Gore® Excluder® Iliac Branch Endoprosthesis (IBE device). This device is indicated for use with the Gore® Excluder® AAA Endoprosthesis to isolate the common iliac artery from systemic blood flow and preserve blood flow in the external iliac and internal iliac arteries in patients with a common iliac or aortoiliac aneurysm, who have appropriate anatomy, including:

- Adequate iliac/femoral access
- Minimum common iliac diameter of 17 mm at the proximal implantation zone of the IBE
- External iliac artery treatment diameter range of 6.5 – 25 mm and seal zone length of at least 10 mm
- Internal iliac artery treatment diameter range of 6.5 – 13.5 mm and seal zone length of at least 10 mm; **AND**
- Adequate length from the lowest major renal artery to the internal iliac artery to accommodate the total endoprosthesis length, calculated by adding the minimum lengths of required components, taking into account appropriate overlaps between components.

In 2020, the FDA recalled the Gore Excluder Iliac Branch Endoprosthesis related to reports of leading end catheter component separations. Recall event ID 84533.

Product code: MIH

Medical Policy Statement

Endovascular repair of the iliac artery using a bifurcated endoprosthesis from the common iliac artery into both the external and internal iliac arteries is experimental/investigational. It has not been scientifically demonstrated to be as safe and effective as conventional treatment.

Inclusionary and Exclusionary Guidelines

N/A

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes

N/A

Other codes (investigational, not medically necessary, etc.)

34717

34718

Rationale

Studies comparing outcomes for open and endovascular repair of isolated iliac artery aneurysms reveal favorable outcomes for endovascular repair. However, because isolated iliac artery aneurysms are rare, so is the availability of large scale prospective, randomized trials. The clinical literature and small scale studies suggest that endovascular repair is a safe, effective and technically feasible alternative to open surgical repair for isolated iliac artery aneurysm in patients whose anatomy is appropriate. Researchers generally concurred that further studies with longer follow up are required.

Choi et al (2021) compared occluded limbs with patent limbs during the follow-up period of iliac limb stent grafting to the external iliac artery using variables, including anatomical values, demographics, and other factors. From 2007 to 2016, 766 iliac limbs from 383 participants who underwent endovascular abdominal aneurysm repair were initially included in our analysis. Among them, 134 iliac limbs underwent limb extension to the external iliac artery. The limb extension was a significant risk factor for occlusion (hazard ratio = 6.34, $P < 0.001$). Occlusion occurred in 10 participants who underwent iliac limb extension. The size of common iliac artery was associated with occlusion. The most significant factor was iliac bifurcation diameter (patent vs. occluded limbs, 21.6 ± 7.6 vs. 27.5 ± 9.5 mm, $P = 0.005$). Subgroup analysis revealed that the common iliac artery of the early occlusion subgroup was generally more tortuous (1.16 ± 0.33 vs. 1.47 ± 0.25 , $P = 0.091$) and longer (53 ± 24 vs. 74 ± 9 , $P = 0.01$) than those of the patent limb group. In addition, the external iliac artery diameters of the late occlusion subgroup were narrower than those of the patent limb group (10.9 ± 1.6 mm vs. 9.1 ± 0.8 mm, $P = 0.011$). Using the log-rank test, those individuals with an external iliac artery diameter narrower than 10.1 mm had a higher risk for late limb occlusion (log-rank $\chi^2 = 5.73$, $P = 0.017$) and the patients who did not take at least a single antiplatelet agent had a

significantly higher chance of limb occlusion (log-rank $\chi^2 = 11.029$, $P = 0.001$). In addition, the patients who did not take a statin had a higher risk for late limb occlusion (log-rank $\chi^2 = 7.41$, $P = 0.007$). Authors concluded that among patients who underwent endovascular abdominal aneurysm repair with iliac limb extension, the common iliac artery length affected early limb occlusion and predisposed patients to vessel injury or stent-graft kinking, and there was the possibility that common iliac artery tortuosity was associated with a higher risk. The late occlusion subgroup had narrower external iliac artery than the patent limb group.

Mendes et al (2019) evaluated perioperative outcomes of individuals with iliac aneurysms treated by open surgery versus endovascular repair with iliac branch endoprosthesis. Treatment of common and internal iliac aneurysms is usually done by open surgery. The study was a retrospective, single-center review of patients who were treated for aortoiliac or isolated common and/or internal iliac artery aneurysms from 2014 to 2017. Patients with connective tissue disorders, infected grafts, or thoracoabdominal aneurysms were excluded. Primary outcomes were perioperative mortality, length of hospital (LOS) and intensive care unit (ICU) stay, estimated blood loss, need for red blood cell transfusion (RBC), and perioperative reinterventions. Sixty-seven patients (96% male) were treated with OS ($n = 25$, mean age 68 ± 8 years) or IBE ($n = 42$, mean age 73 ± 8 years; $P = 0.02$) with 1 symptomatic patient in each group. Perioperative mortality occurred in 1 patient in the OS group (4%), with no mortality in the IBE group ($P = 0.37$). Total LOS and ICU stay was higher for OS compared to IBE (total stay 7.5 ± 3.4 vs. 1.7 ± 1.4 days for IBE, $P < 0.0001$ and ICU LOS 3.3 ± 2.1 vs. 0.1 ± 0.4 days, $P < 0.0001$). Estimated blood loss was higher for patients undergoing OS ($4,732 \pm 2,540$ mL) compared to patients treated with IBE (263 ± 451 mL, $P < 0.0001$), resulting in higher RBC transfusion requirements (1.5 ± 2.4 vs. 0.2 ± 0.8 units, $P = 0.001$). Five patients in the OS group had early procedure-related reinterventions, while 2 patients in the IBE group required reintervention for access site complications (20% vs. 4.7%, $P = 0.09$). The authors concluded that endovascular repair of iliac aneurysms with IBE is feasible and is associated with lower blood loss, LOS and ICU stay and had lower RBC transfusion requirements. However, cost analysis and long-term follow-up will be needed to define the value of this modality for iliac artery aneurysm repair.

Ongoing Clinical Trials

An online search of ClincalTrials.gov identified clinical trials in progress.

Table 1.

Clinical Trial Identifier	Purpose	Number of Participants	Completion Date
NCT02345005	A prospective, nonrandomized, multicenter single-arm study regarding the safety and efficacy of GORE EXCLUDER® iliac branch endoprosthesis in subjects with common iliac artery aneurysms or aorto-iliac aneurysms. The primary endpoints for effectiveness will be measured at 1 month, 6 months, 1 year and then yearly up to 5 years in order to collect long-term clinical data.	100	July 2025

NCT: National clinical trial

Government Regulations
National

Medicare has no National Coverage Determination on this topic.

Local

Non-coronary Vascular Stents (L35998) Effective 10/1/15; Revision 1/1/23

Percutaneous Transluminal Angioplasty (PTA) and stenting of vessels is covered only when all of the following conditions are met:

- The patient has undergone prior thorough medical evaluation and management of symptoms. See below under specific categories for guidelines on medical evaluation and management recommendations.
- Surgical intervention would otherwise be considered as an alternative treatment for the patient.
- A stent may be placed as a planned adjunct to PTA rather than in response to a suboptimal or failed PTA (so-called primary stent deployment). Primary stenting is justified for situations where PTA alone is not expected to provide a durable result, such as: arterial or venous occlusions that carry a high risk for distal embolization or rapid recurrence OR occlusive lesions known to be unfavorable for PTA alone, such as significantly calcified lesions, eccentric lesions, lesions related to external compression (e.g., May-Thurner syndrome and malignant compression of the superior vena cava) or ostial renal artery stenosis.

Coverage for non-coronary vascular stents depends on the use of an FDA approved stent. Several different stents are currently used in the medical community. Each device has specific indications described by the FDA for approved market uses. Stent placement is covered by Medicare only when an FDA approved stent is:

- Used for the FDA approved indications, **OR**
- Used for the above indications when supported by peer-reviewed medical literature.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

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2. Choi E, Lee SA, Ko GY, Kim N, Cho YP, Han Y, Kwon TW. Risk Factors for Early and Late Iliac Limb Occlusions of Stent Grafts Extending to the External Iliac Artery after Endovascular Abdominal Aneurysm Repair. *Ann Vasc Surg*. 2021 Jan;70:401-410. doi: 10.1016/j.avsg.2020.06.028. Epub 2020 Jun 26. PMID: 32599115.
3. Fossaceca, R. et al., "Isolated iliac artery aneurysms: a single-centre experience," *La radiologia medica*, 2014, DOI: 10.1007/s11547-014-0468-y [Epub October 2014].
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5. Kassaian, S et al., "Endovascular treatment of isolated bilateral internal iliac artery aneurysms with a branched endograft: A case report," *J Tehran Heart Cent*, April 2013, Vol. 8, No. 2, pp. 116-118.

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13. U.S. Food and Drug Administration. "Gore® Excluder® Iliac Branch Endoprosthesis." 2016. http://www.accessdata.fda.gov/cdrh_docs/pdf2/P020004S123A.pdf. Accessed February 15, 2025.
14. U.S. National Institutes of Health, "Iliac Branch Excluder ReGistry (IceBERG)," *Clinical Trials*, 2014, Last updated July 21, 2023; <http://clinicaltrials.gov/show/NCT01883999>. Accessed February 15, 2025.
15. Wisconsin Physicians Service Insurance Corporation, "Non-coronary Vascular Stents," LCD 35998, original effective date 10/1/15, revision effective date 1/1/23; <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35998&ver=34&keyword=Non-coronary%20Vascular%20Stents&keywordType=starts&areaid=s27&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1>. Accessed February 5, 2025.
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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 2/5/25, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
5/1/11	3/17/11	3/3/11	Joint policy established
7/1/12	4/10/12	5/18/12	Routine maintenance
1/1/14	10/17/13	10/25/13	Routine maintenance
5/1/15	2/17/15	2/27/15	Routine maintenance
7/1/16	4/19/16	4/19/16	Routine maintenance
7/1/17	4/18/17	4/18/17	• Routine maintenance • Added FDA approval for Gore Excluder
7/1/18	4/17/18	4/17/18	• Routine maintenance • 0254T revised; 0255T deleted
7/1/19	4/16/19		Routine maintenance
7/1/20	4/14/20		• Routine maintenance • 0254T replaced with 34717 and 34718
7/1/21	4/20/21		Routine maintenance
7/1/22	4/19/22		Routine maintenance
7/1/23	4/18/23		Routine maintenance (slp) Vendor managed: N/A
7/1/24	4/16/24		Routine maintenance (slp) Vendor managed: N/A
7/1/25	4/15/25		Routine maintenance (slp) Vendor managed: N/A

Next Review Date: 2nd Qtr, 2026

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: ENDOVASCULAR REPAIR OF ILIAC ARTERY BIFURCATION

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Not covered
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.

