Premier
Summary of Benefits
PPO Plan

Important Information about your Anthem health plan

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
This Summary of Benefits explains the extent to which covered services are available to covered persons on your policy. Your copayments, coinsurance, and/or limits for covered services are shown below and are per covered person. This summary is not a complete explanation of these benefits. To understand them, you must also read your Premium Explanation, your policy, and any endorsements.

Important: This summary of benefits is only a guide, not an official insurance policy. If there is any difference between this document and the information in your policy, please understand that your policy overrides this document.

### Calendar Year Deductible

<table>
<thead>
<tr>
<th>Deductible Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$8,000</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$16,000</td>
</tr>
</tbody>
</table>

### Calendar Year Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>Deductible Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Family</td>
<td>$10,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

### How family deductibles and family out-of-pocket maximums work

For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual can contribute more than their individual deductible or out-of-pocket maximum.

### The following table contains a summary of the benefits available under your policy, including applicable limitations to covered services.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance travel</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Dental accident services</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Diabetic supplies, equipment, and education</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Doctor visits</td>
<td>$30</td>
<td>30%</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Early intervention services - $5,000 limit per benefit period</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Home health care services - 90 visits per benefit period</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospice care services</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital services - Inpatient and Outpatient</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
<tr>
<td>Mental health and substance abuse services</td>
<td>20% or 0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

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Covered Benefit Description – Please see your ID card for deductible and coinsurance you selected.

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial day program – up to 10 inpatient days may be exchanged for 15 partial days</td>
<td>20% or 0%</td>
</tr>
<tr>
<td>Outpatient – 20 visit limit per benefit period</td>
<td></td>
</tr>
<tr>
<td>Inside Physician’s Office</td>
<td></td>
</tr>
<tr>
<td>Visits 1 – 5 – Primary Care - See ID card for your copayment amount</td>
<td>$30</td>
</tr>
<tr>
<td>Visits 1 – 5 – Specialty Provider - See ID card for your copayment amount</td>
<td>$40</td>
</tr>
<tr>
<td>Visits 6 – 20</td>
<td>50%</td>
</tr>
<tr>
<td>Outside Physician’s Office</td>
<td></td>
</tr>
<tr>
<td>Visits 1 – 5</td>
<td>20% or 0%</td>
</tr>
<tr>
<td>Visits 6 – 20</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient Therapy services (see Hospital services for Inpatient services)</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy, Infusion therapy, Radiation therapy, Respiratory therapy</td>
<td>20% or 0%</td>
</tr>
<tr>
<td>Physical and/or Occupational therapy – 20 combined visit limit per benefit period</td>
<td>20% or 0%</td>
</tr>
<tr>
<td>Speech therapy – 20 visit limit per benefit period</td>
<td>20% or 0%</td>
</tr>
<tr>
<td>Skilled nursing facility stays – 100 day limit per benefit period</td>
<td>20% or 0%</td>
</tr>
<tr>
<td>Spinal manipulation &amp; other manual medical interventions</td>
<td>15 visit limit per benefit period</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>$30</td>
</tr>
<tr>
<td>Specialty Care Providers</td>
<td>$40</td>
</tr>
<tr>
<td>Surgery - Inpatient &amp; outpatient</td>
<td>20% or 0%</td>
</tr>
<tr>
<td>Wellness services – Deductible does not apply in-network</td>
<td></td>
</tr>
<tr>
<td>Routine office visit</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>0%</td>
</tr>
<tr>
<td>Specialty Care Providers</td>
<td>0%</td>
</tr>
<tr>
<td>Preventive Care &amp; Immunizations for Children ages 6 and under</td>
<td></td>
</tr>
<tr>
<td>Office visits at specified intervals, immunizations &amp; screening tests</td>
<td>0%</td>
</tr>
<tr>
<td>Lab, x-rays &amp; immunizations</td>
<td>0%</td>
</tr>
<tr>
<td>Routine Pap Test</td>
<td></td>
</tr>
<tr>
<td>One per benefit period</td>
<td>0%</td>
</tr>
<tr>
<td>Routine Fecal Occult blood test</td>
<td></td>
</tr>
<tr>
<td>One per benefit period</td>
<td>0%</td>
</tr>
<tr>
<td>Routine Mammography screening</td>
<td></td>
</tr>
<tr>
<td>One per benefit period for ages 35 &amp; older</td>
<td>0%</td>
</tr>
<tr>
<td>Prostate screening exam – age 50 and older or age 40 – 49 for those at high risk for prostate cancer according to the American Cancer Society</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>0%</td>
</tr>
<tr>
<td>Specialty Care Providers</td>
<td>0%</td>
</tr>
<tr>
<td>Prostate specific antigen test – one per benefit period</td>
<td>0%</td>
</tr>
<tr>
<td>Colorectal cancer screening – In accordance with the ages, family histories, and frequencies referenced in the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American cancer Society.</td>
<td></td>
</tr>
<tr>
<td>Appropriate flexible sigmoidoscopy, colonoscopy, or radiologic imaging</td>
<td>0%</td>
</tr>
<tr>
<td>Routine vision care – Deductible does not apply in-network or out-of-network.</td>
<td></td>
</tr>
<tr>
<td>One routine eye examination per benefit period. In order to receive in-network benefits, services should be received from a Blue View Vision Network provider. For out-of-network care, you will be responsible for the difference between the allowance and the provider's charge.</td>
<td></td>
</tr>
<tr>
<td>Outpatient prescription drugs – Deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Non-Specialty) Drugs</td>
<td>The greater of $15 copayment OR 40% coinsurance</td>
</tr>
<tr>
<td>Tier 2 (Specialty) Drugs</td>
<td>40% coinsurance up to a $10,000 out-of-pocket maximum per person per benefit period</td>
</tr>
<tr>
<td>Optional coverage – if your policy includes one or more of the following coverage options, please see below for more information</td>
<td>Dental</td>
</tr>
<tr>
<td>Term Life</td>
<td>Maternity</td>
</tr>
</tbody>
</table>

*Coinsurance will be 20% or 0% if deemed a medical emergency as defined by Anthem.

Additional Limitations

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
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In addition to any limitations noted in the Covered Benefit Summary, the following apply:

- **Prescription Drugs**
  - When dispensed at a retail pharmacy, up to 34 days supply or no more than 150 units per prescription, whichever is less
  - When ordered through mail order, up to 90 days supply per prescription

- **Coinsurance Limitations** – There are some coinsurance amounts you are always responsible for, even when you have met your deductible and out-of-pocket expense limit, and even if the coinsurance choice for your base policy is 0%.
  - Coinsurance and copayments for prescription drugs and insulin.

**What’s Not Covered**

- **Pre-existing conditions** – any medical condition you had in the 12 months before your “effective date,” or the date you are officially covered by the new policy. For members age nineteen (19) and older, during the first 12 months after your effective date, this plan does not cover prescription drugs prescribed for a pre-existing condition, services for, or complications resulting from, a pre-existing condition. The waiting period for pre-existing conditions may be shorter, or waived, if you’re transferring your coverage from a qualifying health plan. The pre-existing condition limitation does not apply to members under age nineteen (19).
- **Preventive care services** – the policy only covers preventive care specified in the policy. It does not cover routine physical examinations, routine laboratory tests or routine x-rays that exceed what is specifically provided for in the policy.
- **Services not medically necessary** – services or care that are not medically necessary as determined by us, at our sole discretion. We cover only medically necessary services in order to keep everyone's premiums down and to make sure services are provided in a safe, approved setting. Our licensed medical staff uses careful guidelines based on accepted medical practice to determine whether a service is medically necessary. These guidelines apply to everyone. You can find out whether a particular service or procedure is medically necessary and covered before you receive it, by calling us when you’re considering treatment options with your physician. We’ll work with you to find the safest and most effective treatment.
- **Services that are deemed experimental or investigative** – services that we deem, at our sole discretion, to be experimental or investigative, as well as services related to or complications from such procedures, except in certain limited circumstances as listed in the policy. The Blue Cross and Blue Shield Association has a committee of medical professionals that reviews new medical treatments, examines the current scientific medical literature and recommends coverage for those treatments that are shown to be safe and effective. They do not recommend new treatments that are still experimental or under investigation. Our medical staff follows the committee’s recommendations and guidelines to decide whether a new treatment can be covered by the policy.
- **Organ and tissue transplants, transfusions** – certain organ or tissue transplants that are considered life-threatening to the mother. We do not cover family planning services including services and prescription drugs prescribed for or related to artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception. We also do not cover reversals of sterilization which resulted from a previous elective sterilization.
- **Dental services** – except as specifically provided for in the policy.
- **Hearing services** – implantable or removable hearing aids, including exams for prescribing or fitting hearing aids, regardless of the cause of hearing loss, with the exception of cochlear implants.
- **Vision services** – services for, or related to, procedures performed on the cornea to improve vision, in the absence of trauma or previous therapeutic process. Medical or surgical procedures to correct nearsightedness, far-sightedness, and/or astigmatism.
- **Foot care** – services for palliative or cosmetic foot care.
- **Cosmetic services** – all medical, surgical, and mental health services for or related to cosmetic surgery and/or cosmetic procedures, including any medical, surgical, and mental health services to correct complications of a person’s cosmetic procedure. Body piercing and cosmetic tattooing are considered cosmetic procedures. “Cosmetic surgery,” however, does not mean reconstructive surgery incidental to or following surgery caused by trauma, infection, or disease of the involved part. We determine, in our sole discretion, whether surgery is cosmetic or is clearly essential to the physical health of the patient.
- **Certain therapies** – therapy primarily for vocational rehabilitation; certain drugs and therapeutic devices, including over-the-counter drugs and exercise equipment; outpatient services for marital counseling, coma-stimulation activities, educational, vocational, and recreational therapy, manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.
- **Certain facility and home care** – services for rest cures, residential care or custodial care. Your coverage does not include benefits for care from a residential treatment center or non-skilled, subacute settings, except to the extent such settings qualify as substance abuse treatment facility licensed to provide a continuous, structured, 24 hour-a-day program of drug or alcohol treatment and rehabilitation including 24 hour-a-day nursing care.
- **Transportation services** – travel or transportation, except by professional ambulance services as described in the policy.
- **Services covered under government programs or employee benefits** – services covered under Federal or state programs (except Medicaid); services for injuries or sickness resulting from activities for wage or profit when 1) your employer makes payment to you because of your condition; 2) your employer is required by law to provide benefits to you; or 3) you could have received benefits for your condition if you have complied with the relevant law.
• Services related to the military, war, or civil disobedience – services for injuries or sickness while serving in any branch of the armed forces or resulting from acts of war; and services for injuries or sickness resulting from participation in a felony, riot or any other act of civil disobedience.

• Services provided by family or co-workers – services performed by your immediate family or by you; services rendered by a provider to a co-worker for which no charge is normally made in the absence of insurance.

• Separate charges for services by health care professionals employed by a covered facility which makes those services available.

• Non-interactive telemedicine services. Non-interactive telemedicine services include an audio-only telephone, electronic mail message, or facsimile transmission.

• Prescription drugs:
  o Prescription drugs prescribed for pre-existing conditions during the first 12 months of coverage. The pre-existing condition limitation does not apply to member under age nineteen (19).
  o Over-the-counter drugs.
  o Charges to administer prescription drugs or insulin, except as stated in the policy.
  o Prescription refills that exceed the number of refills specified by the provider.
  o A prescription that is dispensed more than one year after the order of a physician.
  o Drugs that are consumed or administered at the place where they are dispensed, except as stated in the policy.
  o Prescription drugs prescribed for weight loss or as stop-smoking aids.
  o Prescription drugs prescribed primarily for cosmetic purposes.
  o Prescription drugs dispensed by anyone other than a pharmacy with the exception of a physician dispensing a one-time dosage of an oral medication either at the physician’s office or in a covered outpatient setting in order to treat an acute situation.
  o Prescription drugs not approved by the FDA.

• Other non-covered services:
  o Services for which a charge is not normally made.
  o Amounts above the allowable charge for a service.
  o Services or supplies not prescribed, performed or directed by a provider licensed to do so.
  o Services if they are for dates of service before the effective date or after a covered person’s coverage ends.
  o Telephone consultations, charges for not keeping appointments, or charges for completing forms or copying medical records.
  o Services not specifically listed or described in this policy as covered services.
  o Services to treat sexual dysfunction, including services for or related to sex transformation, when the dysfunction is not related to organic disease. This includes related medical services and mental health services.
  o Complications of non-covered services — these services would include treatment of all medical, mental health and surgical services related to the complication.
  o Services or supplies ordered by a physician whose services are not covered under the policy.
  o Self-help, training, and self-help administered services.
  o Manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.

• Out-of-pocket maximum exclusions:
  o Coinsurance paid to a non-participating facility;
  o Amounts exceeding the allowable charge;
  o Amounts over any policy maximum or limitation; and
  o Expenses for services not covered under the policy;
OPTIONAL SUPPLEMENTAL ACCIDENT COVERAGE

AVAILABLE WITH PREMIER, SMARTSENSE, SMARTSENSE WITH ENHANCED DRUG, CORESHARE, KEYCARE FLEXIBLE CHOICE, KEYCARE HEALTHSMART AND KEYCARE HEALTHSMART WITH ENHANCED DRUG BENEFIT

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As a supplement to the emergency care benefit included in your medical plan, Supplemental Accident Coverage provides coverage for services or supplies used to diagnose or treat an injury caused by an accident. Examples of accidents include: animal bites, choking on food or foreign objects; frostbite; and poisoning. Damage to teeth while eating is not considered an accidental injury and is not covered. We cover allowable charges for covered services received within 90 days of the accident only if the first treatment occurs within 30 days of the accident.

Supplemental Accident Coverage provides the following benefits:

• Pays 100% of the allowable charges for care related to an accident
• Benefits are paid prior to any applicable deductible on your medical policy
• Pays up to $750 per person per calendar year

What’s Not Covered

• Exclusions listed in the your policy apply.
• Insulin or other prescription drugs, including specialty drugs
• The amount of a provider’s charge which exceeds our allowable charge. This portion of the provider’s charge will not be counted towards your out-of-pocket expense limit.

For more details, please refer to your policy documents.
## Optional Dental Coverage

ANTHEM BLUE CROSS AND BLUE SHIELD
SCHEDULE OF BENEFITS

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### Available with Premier, SmartSense, SmartSense with Enhanced Drug, Coreshare, Keycare Flexible Choice, Basic Keycare, Essential Keycare, Keycare HSA, Keycare Healthsmart, Keycare Healthsmart with Enhanced Drug Benefit, Lumenos HSA Plus, Lumenos HSA, Lumenos HIA, Lumenos HIA Plus and Lumenos HSA Standard

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The following table contains a summary of the benefits available when this optional coverage is added to your medical policy, including applicable limitations to covered services. The maximum covered per year is $1,000 per covered person for preventive, restorative and complex care.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Waiting Period</th>
<th>Coinsurance In-network</th>
<th>Coinsurance Out-of-network</th>
<th>Deductible In-network</th>
<th>Deductible Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic oral exams</td>
<td>None</td>
<td>0%</td>
<td>50%</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>X-rays</td>
<td>None</td>
<td>0%</td>
<td>50%</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Preventive services</td>
<td>None</td>
<td>0%</td>
<td>50%</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Restorative and Complex Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative services (filings)</td>
<td>6 months</td>
<td>50%</td>
<td>50%</td>
<td>$50 per individual up to $150 per family</td>
<td>$100 per individual up to $300 per family</td>
</tr>
<tr>
<td>Simple extractions</td>
<td>6 months</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia (emergency treatment of dental pain for minor procedures, general anesthesia with oral surgery)</td>
<td>6 months</td>
<td>50%</td>
<td>50%</td>
<td>$50 per individual up to $150 per family</td>
<td>$100 per individual up to $300 per family</td>
</tr>
<tr>
<td>Oral Surgery (includes root removal, treatment of abscess)</td>
<td>18 months</td>
<td>50%</td>
<td>50%</td>
<td>$50 per individual up to $150 per family</td>
<td>$100 per individual up to $300 per family</td>
</tr>
<tr>
<td>Prosthodontic services (includes onlays, crowns, dentures)</td>
<td>18 months</td>
<td>50%</td>
<td>50%</td>
<td>$50 per individual up to $150 per family</td>
<td>$100 per individual up to $300 per family</td>
</tr>
<tr>
<td>Endodontic services (root canals)</td>
<td>18 months</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal services (includes periodontal cleaning, scaling, and root planning)</td>
<td>18 months</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Limitations

In addition to any limitations noted in the Covered Benefit Summary, the following apply:

- Covered diagnostic evaluations including dental and periodontal cleanings - 2 per member per calendar year.
- Bitewing x-rays – 1 per member per calendar year, not in the same year as full mouth series x-rays.
- Full mouth series x-rays for members age 5 and over – 1 per member every 3 calendar years.
- Nine or more bitewing or periapical x-rays taken at one time will be considered a full mouth x-ray.
- Up to four individual periapical films, but not in the same year as a complete mouth x-ray series (does not apply when rendered in conjunction with emergency treatment).
- Fluoride application for covered members under age 16 – 2 per member per calendar year.
- Space maintainers for covered members under age 12 – 2 each per lifetime.
- Sealants for each unrestored permanent first and second molar for covered persons under age 16: 1 each per lifetime. There must be a lapse of at least 2 years from the time sealants are placed and the time a restoration is performed on the same tooth and surface for benefits to apply.
- One amalgam or resin restoration (filling) per tooth per surface, one per calendar year. White-colored composite resin fillings will only be covered on anterior (front) teeth. If composite resin fillings are done on back teeth, then you are responsible for the difference between our allowable charge and the dentist’s charge for amalgam filling restoration.
- One pin retention per tooth per calendar year.
- One stainless steel crown on each primary (baby) tooth – one each per lifetime.
- Root canal (anterior, bicuspid, or molar) – one per tooth every three calendar years.
• Retreat of previous root canal (anterior, bicuspid, or molar) – one per tooth per lifetime
• Apicoectomy/periradicular surgery (anterior, bicuspid, molar, or additional root) – one per root or tooth per lifetime.
• Retrograde filling – one per root or tooth per lifetime.
• Root canal is covered only on permanent teeth.
• Therapeutic pulpotomy is covered only on primary (baby) teeth.
• Periodontal cleaning (applies to your 2 cleanings per year) – one per calendar year.
• Periodontal scaling and root planing – one per quadrant every two calendar years.
• Gingivectomy or gingivoplasty – one per quadrant every three calendar years.
• Periodontal osseous (bone) surgery – one per quadrant every three calendar years.
• Full mouth debridement – one per member per lifetime.
• Services for bridges, crowns, and dentures are only covered for teeth extracted or missing after the rider’s effective date, which includes initial placement, unless for an existing bridge more than 5 years old
• Adjustment or repair to partial or complete dentures – one per member per calendar year
• Chairside relining of partial or complete dentures – one every two calendar years.
• One onlay, crown or bridge per tooth every 5 calendar years.
• One partial or complete denture per member every 5 calendar years.
• One laboratory rebasing or relining of dentures per member every 5 calendar years.
• One crown repair per tooth per lifetime.
• One crown recementation per tooth per lifetime.
• Use of anesthesia only in conjunction with surgical procedures.
• One vestibuloplasty per member every three calendar years.
• One palliative (emergency) treatment per member per calendar year.

What’s Not Covered
• Services not listed or described in your policy or in the optional coverage as a covered service.
• Dental services that are covered under any other dental benefits plan under which a covered person is enrolled.
• Dental services with respect to congenital or developmental malformation or primarily for cosmetic purposes except as specified in the optional coverage.
• Upgrading of serviceable dentistry.
• Services rendered prior to the optional coverage effective date, and services rendered on or after the optional coverage effective date that are directly related to services received before the optional coverage effective date.
• Services rendered after the date of termination of the dental coverage.
• Dental pit/fissure sealants on other than first and second permanent molars.
• Diagnostic photographs.
• Dietary instruction or other counseling.
• Silicate restorations.
• Sedative fillings; root canal therapy on other than permanent teeth; pulp capping (direct or indirect).
• Separate charges for pulp vitality tests and bases and liners under restorations.
• Therapeutic pulpotomy on other than primary teeth.
• Guided tissue regeneration, including flap entry or re-entry and closure.
• Gingival curettage.
• Separate charges for irrigation or re-evaluation following periodontal therapy.
• Periodontal splinting and occlusal adjustments for periodontal purposes.
• Controlled release of medications to tooth crevicular tissues for periodontal purposes.
• Repositioning appliances or restorations necessary to increase vertical dimensions or restore or correct the occlusion.
• Services rendered for purposes other than to eliminate oral disease and/or replace covered missing teeth (mouth rehabilitation).
• Gold foil restorations.
• Inlays.
• Temporary dentures or temporary crowns, or duplicate dentures.
• Services to replace teeth that were lost or extracted prior to the rider’s effective date.
• Services to replace non-functioning teeth.
• Fixed bridges when done in conjunction with a removable appliance in the same arch.
• Precision attachments for dental appliances.
• Tissue conditioning.
• Prefabricated resin crowns.
• Dental implants and associated services in conjunction with implants.
• Consultations (including telephone consultations), charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for providing information in connection with a claim.
• Occlusal guards and athletic mouth guards.
• Bleaching or whitening of discolored teeth.
• Behavior management or hypnosis.
• Therapeutic injections.
• Orthodontic services.
• Separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements.
• Analgesics (nitrous oxide).
• Occlusal analysis.
• Tooth desensitizing treatments.
• When coverage is available for the following services, these services require the performance of diagnostic x-rays six months prior to the earlier of (1) the request for predetermination of such services or (2) the date the services were rendered:
  o More than one (1) crown
  o Fixed prosthetic devices.
  o Surgical extraction of impacted teeth.
If diagnostic x-rays are not performed as specified above, the services listed above are not covered.
OPTIONAL MATERNITY COVERAGE

AVAILABLE WITH PREMIER, KEYCARE FLEXIBLE CHOICE, BASIC KEYCARE, KEYCARE PREFERRED, KEYCARE HSA, KEYCARE HEALTHSMART, KEYCARE HEALTHSMART WITH ENHANCED DRUG BENEFIT, LUMENOS HSA PLUS, LUMENOS HSA, LUMENOS HIA, LUMENOS HIA PLUS, LUMENOS HSA STANDARD AND INDIVIDUAL KEYCARE

(LIMITED TO SPECIFIC DEDUCTIBLES ON CERTAIN PRODUCTS)

As a supplement to the benefits included in your medical plan, Maternity Coverage provides the following benefits subject to the same coinsurance amounts as the base medical plan:

- childbirth;
- prenatal care;
- postnatal care;
- use of delivery room;
- hospital bed and board for mother and newborn;
- routine newborn nursery supplies;
- routine newborn screenings;
- routine newborn physician services rendered in newborn nursery;
- routine circumcision of a newborn male;
- cesarean section;
- voluntary surgical termination of pregnancy;
- diagnostic laboratory and x-rays; and
- home visits - Please see the Home Health Care Services provision in the “What is Covered” chapter of your policy for details concerning home visits.

Admission review is required for all inpatient hospital services except for hospital stays for vaginal or cesarean deliveries without complications. Pre-authorization may be required for certain diagnostic services. Pre-authorization is always required for home visits.

Limitations

- Conception must occur at least 6 months after the effective date of the optional maternity coverage
- This coverage cannot be added to a policy insuring one male without a female spouse or female domestic partner
- This coverage cannot be added for applicants under age 18 unless they are female emancipated minors
- If you are a HIPAA eligible individual as defined on the application, an conception has occurred prior to the effective date of the optional maternity coverage, the six month waiting period is waived. HOWEVER, if conception occurs on or after the effective date, the pregnancy will not be covered unless the six month waiting period has expired.

What’s Not Covered

- Pregnancy that occurs prior to the completion of the six month waiting period, except as noted above
- Pregnancy for any covered minor dependents

For more details, please refer to your policy documents.