# A Better Path to Benefits

Dominion National recognizes that you're a unique individual and we've designed plans and programs that work for you. We seek a better way to serve you through customized plans and exceptional service so that you can focus on what makes you extraordinary and fulfilled.

## WE WORK FOR THE BENEFIT OF OUR MEMBERS, DELIVERING:

### EXTENSIVE NETWORKS[2]

Choice PPO network offers access to over 350,000 dentists nationally.[1,3]

Elite PPO and Elite ePPO networks provide unmatched flexibility and lower out-of-pocket costs.

Select Plan network is one of the largest in the Mid-Atlantic region.[3,4]

To find a participating provider, please visit **DominionNational.com.**

### SECURE ONLINE ACCESS

Access your digital ID card, find a provider and more through secure online resources.

#### MEMBER PORTAL
DominionMembers.com

#### GO MOBILE COMMUNICATION SERVICE
Register at DominionNational.com/go or by calling 888.596.0716

#### LIVE CHAT SUPPORT
Visit DominionNational.com to chat with a live agent.

### TOLL-FREE, 24 HOUR ACCESS at 888.518.5338

Eligibility and claim information are available for members, benefit administrators and dentists.

### VALUE-ADDED BENEFITS

#### HEARING DISCOUNT PROGRAM
amplifonusa.com/dn
Access to discounts on hearing aids and services.[5]

#### DIGIBITE TELEDENTISTRY APP
DominionNational.com/teledentistry
Receive a dental consultation without leaving your home or office!

#### Z DENTAL DISCOUNT
Myzsonic.com/DN
Access exclusive discounts on premium oral care products and accessories offered by Z Dental.

1 Dominion National Internal Performance Report, 2022.
2 Networks and products vary by state. Check availability on your state marketplace.
3 Participating providers are subject to change.
4 Managed care plan with exclusive network, fixed member copayments, no annual maximum dollar limits, no waiting periods and no deductibles. In New Jersey, Select Plans are available in Camden, Cumberland and Gloucester counties only. Dominion National Network Analysis Report, 2023. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.
5 Visit amplifonusa.com/dn for full details. Hearing services are administered by Amplifon Hearing Health Care Corp.

The dental plan is underwritten by Dominion Dental Services, Inc. (hereinafter referred to as "Dominion").

# Elite PPO Basic (DC)
# Coverage Schedule, Limitations and Exclusions for Adult Services (age 19 and over)

| Service Class | Service Description | In-Network | | Out-of-Network | |
|---|---|---|---|---|---|
| | | Plan Pays | Waiting Period | Plan Pays[2] | Waiting Period |
| | | Y1\|Y2\|Y3[1] | | Y1\|Y2\|Y3[1] | |
| 1 | Diagnostic & Preventive Services | 100%\|100%\|100% | None | 90%\|90%\|90% | None |
| 2 | Basic Services | 50%\|60%\|80% | None | 30%\|50%\|70% | None |
| 3 | Major Services | 15%\|25%\|50% | None | 10%\|20%\|40% | None |
| 4 | Orthodontic Services | 0% | N/A | 0% | N/A |

1. The amount the plan pays for services increases from Year 1 to Year 3, with a maximum plan contribution in Year 3, provided that the member has continuous coverage during each year.

| Annual Deductible | In-Network | Out-of-Network |
|---|---|---|
| Single Adult | $50 | $50 |
| Three or More Adults | $150 | $150 |
| Applies To | Class 1, Class 2 and Class 3 | Class 1, Class 2 and Class 3 |

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible.  For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.

| Maximums | In-Network | Out-of-Network |
|---|---|---|
| Annual | $1,000 | $1,000 |
| Lifetime Orthodontic | N/A | N/A |

- The maximum listed is the dollar amount that the plan will pay towards the cost of dental care within the specified period per member
- The annual maximum is combined for in-network and out-of-network services.
- The annual maximum applies to: Class 1, Class 2, Class 3

| Out-of-Network Allowance | In-Network | Out-of-Network |
|---|---|---|
| | N/A | MAC |

2. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, prior review is recommended.

Plan will pay either the Participating Dentist's negotiated fee or the Maximum Allowable Charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 1 | Evaluations | Two per Calendar Year including a maxmium of one comprehensive evaluation per 36 months | Y1: 100%<br>Y2: 100%<br>Y3: 100% | None | Yes | Y1: 90%<br>Y2: 90%<br>Y3: 90% | None | Yes |
| 1 | Emergency or problem focused exam (D0140) | One per Calendar Year | Y1: 100%<br>Y2: 100%<br>Y3: 100% | None | Yes | Y1: 90%<br>Y2: 90%<br>Y3: 90% | None | Yes |
| 1 | Prophylaxis (cleaning, scaling and polishing teeth) | Two per Calendar Year | Y1: 100%<br>Y2: 100%<br>Y3: 100% | None | Yes | Y1: 90%<br>Y2: 90%<br>Y3: 90% | None | Yes |
| 1 | Bitewing x-rays | Two per Calendar Year | Y1: 100%<br>Y2: 100%<br>Y3: 100% | None | Yes | Y1: 90%<br>Y2: 90%<br>Y3: 90% | None | Yes |
| 1 | Palliative treatment of dental pain – per visit | Only if no services other than exam and x-rays were performed on the same date of service | Y1: 100%<br>Y2: 100%<br>Y3: 100% | None | Yes | Y1: 90%<br>Y2: 90%<br>Y3: 90% | None | Yes |
| 1 | Teledentistry, synchronous (D9995) or asynchronous (D9996) | Must be accompanied by a covered procedure | Y1: 100%<br>Y2: 100%<br>Y3: 100% | None | Yes | Y1: 90%<br>Y2: 90%<br>Y3: 90% | None | Yes |
| 2 | Simple extraction of teeth | | Y1: 50%<br>Y2: 60%<br>Y3: 80% | None | Yes | Y1: 30%<br>Y2: 50%<br>Y3: 70% | None | Yes |
| 2 | Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations) | Excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months | Y1: 50%<br>Y2: 60%<br>Y3: 80% | None | Yes | Y1: 30%<br>Y2: 50%<br>Y3: 70% | None | Yes |
| 2 | Periapical x-rays | | Y1: 50%<br>Y2: 60%<br>Y3: 80% | None | Yes | Y1: 30%<br>Y2: 50%<br>Y3: 70% | None | Yes |
| 2 | Full mouth or panoramic x-ray | One per 60 months | Y1: 50%<br>Y2: 60%<br>Y3: 80% | None | Yes | Y1: 30%<br>Y2: 50%<br>Y3: 70% | None | Yes |
| 2 | Pin retention of fillings | Multiple pins on the same tooth are allowable as one pin | Y1: 50%<br>Y2: 60%<br>Y3: 80% | None | Yes | Y1: 30%<br>Y2: 50%<br>Y3: 70% | None | Yes |
| 2 | Antibiotic injections administered by a dentist | | Y1: 50%<br>Y2: 60%<br>Y3: 80% | None | Yes | Y1: 30%<br>Y2: 50%<br>Y3: 70% | None | Yes |

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 3 | Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/ or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst; marsupialization of odontogenic cyst | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only | One per tooth per lifetime | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: root canal therapy | Not covered if pulp chamber was opened before effective date of coverage | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings | One per root per lifetime | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Periodontic services, limited to: periodontal maintenance | Two per Calendar Year following surgery | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Periodontic services, limited to: scaling and root planing | One per quadrant per 24 months from age 21 | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Periodontic services, limited to: occlusal adjustment performed with covered surgery | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Periodontic services, limited to: pedicle or free soft tissue graft | One per site per lifetime | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 3 | Periodontic services, limited to: occlusal guard (night guards) | One per 5 years within 6 months of osseous surgery | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit | One per lifetime | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Periodontic services, limited to: scaling in presence of generalized moderate or severe gingival inflammation | Full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Study model | One per 36 months | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Crown build-up for non-vital teeth | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Recementing bridges, inlays, onlays and crowns | After first 12 months of insertion and per 12 months per tooth thereafter | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Repair of dentures or fixed bridgework | One per 24 months | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | General anesthesia and analgesia, including intravenous sedation | Covered in conjunction with covered oral surgery, or periodontal surgery | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Infiltration of sustained release therapeutic drug, per quadrant | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Restoration services, limited to: cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown | Limited to a tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Restoration services, limited to: replacement of existing inlay, onlay, or crown | After 7 years of the restoration initially placed or last replaced | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Restoration services, limited to: post and core | Covered in addition to a crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure | One per two years | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Prosthetic services, limited to: initial placement of removable dentures or fixed bridges | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 3 | Prosthetic services, limited to: replacement of removable dentures or fixed bridges | That cannot be repaired after 7 years from the date of last placement | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Prosthetic services, limited to: addition of teeth to existing partial denture | | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 3 | Prosthetic services, limited to: relining or rebasing of existing removable dentures | One per 24 months (only after 24 months from date of last placement) | Y1: 15%<br>Y2: 25%<br>Y3: 50% | None | Yes | Y1: 10%<br>Y2: 20%<br>Y3: 40% | None | Yes |
| 4 | Orthodontia Services Not Covered | Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy | 0% | N/A | N/A | 0% | N/A | N/A |

### Plan Exclusions

Please refer to the section in your Individual Dental Policy titled “State-Specific Exclusions or Exceptions” for additional exclusions and/or exceptions to the following exclusions, if applicable

1. Services which are covered under worker’s compensation or employer’s liability laws.
2. Services which are not medically necessary for the patient’s dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth including third molars.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member’s condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 12 months of Member’s continuous coverage under the plan.

The dental plan is underwritten by Dominion Dental Services, Inc. (hereinafter referred to as "Dominion").

# Elite PPO Basic *Kids* (DC)
# Coverage Schedule, Limitations and Exclusions for Pediatric Services

Coverage continues through end of the year in which the Member turns 19

| Service Class | Service Description | In-Network | | Out-of-Network | |
|---|---|---|---|---|---|
| | | Plan Pays | Waiting Period | Plan Pays[1] | Waiting Period |
| 1 | Diagnostic & Preventive Services | 100% | None | 80% | None |
| 2 | Basic Services | 35% | None | 20% | None |
| 3 | Major Services | 25% | None | 10% | None |
| 4 | Orthodontic Services | 50% | None | 0% | None |

| Annual Deductible | In-Network | Out-of-Network |
|---|---|---|
| Single Child | $100 | $100 |
| Two or More Children | $200 | $200 |
| Applies To | Class 2 and Class 3 | Class 2 and Class 3 |

- Each member must pay the deductible amount for dental services before the plan will begin to cover the member's dental procedures. The deductible is combined for all applicable services for each calendar year per pediatric member - maximum $200 for pediatric members.

| Out-of-Pocket Maximums | In-Network | Out-of-Network |
|---|---|---|
| Single Child | $400 | N/A |
| Two or More Children | $800 | N/A |

- The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.

| Out-of-Network Allowance | In-Network | Out-of-Network |
|---|---|---|
| | N/A | MAC |

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, prior review is recommended.

Plan will pay either the Participating Dentist's negotiated fee or the Maximum Allowable Charge (subject to service coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 1 | Evaluations | One evaluation (D0120, D0140, D0150, D0160 or D0180) per six (6) months, per patient. D0150 limited to once per 12 months | 100% | None | No | 80% | None | No |
| 1 | Prophylaxis (D1110 or D1120) | One per six (6) months, per patient | 100% | None | No | 80% | None | No |
| 1 | Fluoride treatment | One per six (6) months, per patient | 100% | None | No | 80% | None | No |
| 1 | Bitewing x-rays | One set per six (6) months, starting at age two | 100% | None | No | 80% | None | No |
| 1 | Periapical x-rays | Not on the same date of service as a panoramic radiograph | 100% | None | No | 80% | None | No |
| 1 | Full mouth x-ray or panoramic film | One per 60 months (starting at age six); maximum of one set of x-rays per office visit | 100% | None | No | 80% | None | No |
| 1 | Application of caries arresting medicament | One application per primary tooth is covered per lifetime | 100% | None | No | 80% | None | No |
| 1 | Space maintainer | One per 24 months per patient per arch (D1516, D1517, D1526 or D1527) to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); one distal shoe space maintainer (D1575), fixed, unilateral per lifetime. | 100% | None | No | 80% | None | No |
| 1 | Sealants | One per tooth per 36 months (limited to occlusal surfaces of posterior permanent teeth without restorations or decay) | 100% | None | No | 80% | None | No |
| 1 | Teledentistry, synchronous (D9995) or asynchronous (D9996) | Must be accompanied by a covered procedure | 100% | None | No | 80% | None | No |
| 2 | Amalgam and composite fillings | One per tooth per surface every 36 months (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations) | 35% | None | Yes | 20% | None | Yes |
| 2 | Pin retention of fillings | Multiple pins on the same tooth are allowable as one pin | 35% | None | Yes | 20% | None | Yes |
| 2 | Palliative treatment of dental pain – per visit | Only if no services other than exam and x-rays were performed on the same date of service | 35% | None | Yes | 20% | None | Yes |

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 2 | General anesthesia and analgesic | Only when provided in connection with a covered procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions, including intravenous and non-intravenous sedation with a maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure codes D9230, D9239 or D9243; intravenous conscious sedation is not covered with procedure codes D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure codes D9222, D9223 or D9230); requires a narrative of medical necessity be maintained in patient records | 35% | None | Yes | 20% | None | Yes |
| 2 | Occlusal guard | Analysis and limited/complete adjustment, one in 12 months for patients 13 and older, by report | 35% | None | Yes | 20% | None | Yes |
| 2 | Prefabricated stainless steel or porcelain crown | One per 60 months from the original date of placement, per permanent tooth, per patient for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling | 35% | None | Yes | 20% | None | Yes |
| 2 | Addition of teeth to existing partial denture | | 35% | None | Yes | 20% | None | Yes |
| 2 | Relining or rebasing of existing removable dentures | One per 36 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth) | 35% | None | Yes | 20% | None | Yes |
| 2 | Repair of crowns, dentures and bridges | Twice per year and five total per 5 years | 35% | None | Yes | 20% | None | Yes |
| 3 | Oral surgery, including postoperative care for: | Removal of teeth, including impacted teeth | 25% | None | Yes | 10% | None | Yes |
| 3 | Oral surgery, including postoperative care for: | Extraction of tooth root | 25% | None | Yes | 10% | None | Yes |
| 3 | Oral surgery, including postoperative care for: | Alveolectomy, alveoplasty, and frenectomy | 25% | None | Yes | 10% | None | Yes |
| 3 | Oral surgery, including postoperative care for: | Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy | 25% | None | Yes | 10% | None | Yes |
| 3 | Oral surgery, including postoperative care for: | Tooth re-implantation and/or stabilization; tooth transplantation | 25% | None | Yes | 10% | None | Yes |
| 3 | Oral surgery, including postoperative care for: | Excision of a tumor or cyst and incision and drainage of an abscess or cyst, Marsupialization of odontogenic cyst | 25% | None | Yes | 10% | None | Yes |

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 3 | Oral surgery, including postoperative care for: | Coronectomy, intentional partial tooth removal, impacted teeth only, one per lifetime | 25% | None | Yes | 10% | None | Yes |
| 3 | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: | Root canal therapy once per lifetime, per patient, per permanent tooth; retreatment of previous root canal therapy, one per lifetime, not within 24 months when done by same dentist or dental office | 25% | None | Yes | 10% | None | Yes |
| 3 | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: | Pulpotomy; apicoectomy | 25% | None | Yes | 10% | None | Yes |
| 3 | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: | Retrograde fillings, one per root per lifetime | 25% | None | Yes | 10% | None | Yes |
| 3 | Periodontic services, limited to: | Periodontal cleanings, two per calendar year, in addition to adult prophylaxis, within 24 months after definitive periodontal therapy | 25% | None | Yes | 10% | None | Yes |
| 3 | Periodontic services, limited to: | Root scaling and planing, once per 24 months per quadrant per patient | 25% | None | Yes | 10% | None | Yes |
| 3 | Periodontic services, limited to: | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110/D1120, limited to once per two years | 25% | None | Yes | 10% | None | Yes |
| 3 | Periodontic services, limited to: | Gingivectomy, once per 36 months per patient, per quadrant and gingival irrigation with a medicinal agent, per quadrant | 25% | None | Yes | 10% | None | Yes |
| 3 | Periodontic services, limited to: | Osseous surgery including flap entry and closure, once per 36 months per patient, per quadrant | 25% | None | Yes | 10% | None | Yes |
| 3 | Periodontic services, limited to: | Pedicle or free soft tissue graft, one per site per lifetime | 25% | None | Yes | 10% | None | Yes |
| 3 | Periodontic services, limited to: | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per lifetime | 25% | None | Yes | 10% | None | Yes |
| 3 | Study model | One per 36 months | 25% | None | Yes | 10% | None | Yes |
| 3 | Restoration services, limited to: | Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite onlay, or crown for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth, per patient | 25% | None | Yes | 10% | None | Yes |

| Service Class | Service Description | Service Limitation | In-Network | | | Out-of-Network | | |
|---|---|---|---|---|---|---|---|---|
| | | | Plan Pays | Waiting Period (Months) | Does a deductible apply? | Plan Pays | Waiting Period (Months) | Does a deductible apply? |
| 3 | Restoration services, limited to: | Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally; protective restoration; post removal; crown buildup for non-vital teeth | 25% | None | Yes | 10% | None | Yes |
| 3 | Prosthetic services, limited to: | Initial placement of dentures | 25% | None | Yes | 10% | None | Yes |
| 3 | Prosthetic services, limited to: | Replacement of dentures that cannot be repaired after 5 years from the date of last placement | 25% | None | Yes | 10% | None | Yes |
| 3 | Prosthetic services, limited to: | Construction of bridges, replacement limited to once per 60 months | 25% | None | Yes | 10% | None | Yes |
| 3 | Implants and related services | Replacement of implant crowns limited to once per 60 months | 25% | None | Yes | 10% | None | Yes |
| 3 | Infiltration of sustained release therapeutic drug, per quadrant | | 25% | None | Yes | 10% | None | Yes |
| 4 | *MEDICALLY NECESSARY* Orthodontia Services: | Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion | 50% | None | No | 0% | None | N/A |

**Plan Exclusions**

Please refer to the section in your Certificate of Coverage titled State-Specific Exclusions for additional exclusions, if applicable.

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services related to the treatment of TMD (Temporomandibular Disorder).
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth including third molars. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review.
12. Services not listed as covered.
13. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions except if the developmental malformation and/or congenital conditions cause severe, dysfunctional handicapping malocclusion that requires medically necessary orthodontia services.
15. Procedures, that in the opinion of the Plan, are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate (if not treatable through orthodontics), malignancies or neoplasms.
17. Orthodontics is only covered if medically necessary as determined by the Plan. The Invisalign system and similar specialized braces are not a covered benefit. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.