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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.

P.O. Box 21522; Eagan, MN 55121-0522

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

DOMINION® NATIONAL DENTAL

Choice PPO Basic (GA) Coverage Schedule, Limitations and Exclusions for Adult Services

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	100%|100%|100%	None
2	Basic Services	50%|60%|80%	None	50%|60%|80%	None
3	Major Services	15%|25%|50%	None	15%|25%|50%	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.

Services in Class 1 - Class 4 are listed on p. 2 - 5 of this document

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 either the in or 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	
	Maximum Allowable Charge

2. Unlike Participating Dentists that have agreed to negotiated fees for services, Non-Participating Dentists have no contract with Dominion or Dominion's leased dental networks. As such, Non-Participating Dentists set their own fees and Dominion only reimburses the Member based on the Maximum Allowable Charge, a limitation on the billed charges by a Non-Participating Dentist as determined by the geographic area where the expenses are incurred. This means that if the Non-Participating Dentist's fee is higher than Dominion's Maximum Allowable Charge, the Member will be billed the remaining balance to cover the Non-Participating Dentist's fee.

- If course of treatment is to exceed $300, pre-authorization is recommended. This is not mandatory but would allow the Member to see the cost of treatment prior to services.

Plan will pay either the Participating Dentist's In-Network Allowed Amount or the Out-of-Network Maxmium 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	Two per Calendar year including a maxmium of one comprehensive evaluation per 36 months	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 100% Y2: 100% Y3: 100%	None	Yes
1	Emergency or problem focused exam (D0140)	One per Calendar year	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 100% Y2: 100% Y3: 100%	None	Yes
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar year	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 100% Y2: 100% Y3: 100%	None	Yes
1	Bitewing x-rays	Two per Calendar year	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 100% Y2: 100% Y3: 100%	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. Out-of-network emergency palliative treatment is covered at the same cost share as if the Member visited a Participating Dentist	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 100% Y2: 100% Y3: 100%	None	Yes
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 100% Y2: 100% Y3: 100%	None	Yes
2	Simple extraction of teeth		Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 50% Y2: 60% Y3: 80%	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% Y2: 60% Y3: 80%	None	Yes	Y1: 50% Y2: 60% Y3: 80%	None	Yes
2	Periapical x-rays		Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 50% Y2: 60% Y3: 80%	None	Yes
2	Full mouth or panoramic x-ray	One per 60 months	Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 50% Y2: 60% Y3: 80%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 50% Y2: 60% Y3: 80%	None	Yes
2	Antibiotic injections administered by a Participating Dentist		Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 50% Y2: 60% Y3: 80%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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: 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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Study model	One per 36 months	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Crown build-up for non-vital teeth		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	None	Yes
3	Prosthetic services, limited to: addition of teeth to existing partial denture		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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% Y2: 25% Y3: 50%	None	Yes	Y1: 15% Y2: 25% Y3: 50%	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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not Necessary and Appropriate Dental Services 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. 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.
13. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions, except for the Necessary Care and Treatment of medically diagnosed congenital defects and birth abnormalities.
14. 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.
15. Any service or supply rendered to replace a tooth lost prior to the the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

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

DOMINION® NATIONAL DENTAL

Choice PPO Basic *Kids* (GA) 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	100%	None
2	Basic Services	35%	None	35%	None
3	Major Services	25%	None	25%	None
4	Orthodontic Services	50%	None	50%	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, Class 3 and Class 4

- 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, D0145, D0150 or D0160) per six (6) months	100%	None	No	100%	None	No
1	Limited evaluation or re-evaluation, problem focused (D0140 or D0170)	One per six (6) months	100%	None	No	100%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	100%	None	No
1	Fluoride treatment	One per six (6) months	100%	None	No	100%	None	No
1	Bitewing x-rays	One set per six (6) months	100%	None	No	100%	None	No
1	Periapical x-rays	Not on the same date of service as a panoramic radiograph	100%	None	No	100%	None	No
1	Full mouth x-ray or panoramic film	One per 36 months	100%	None	No	100%	None	No
1	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	100%	None	No
1	Space maintainer	Space maintainer (D1510, D1516 or D1517) to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer	100%	None	No	100%	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	100%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	100%	None	No
2	Amalgam and composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; sedative fillings when not billed on the same day as a normal restoration	35%	None	Yes	35%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	35%	None	Yes	35%	None	Yes
2	Crown build-up for non-vital teeth		35%	None	Yes	35%	None	Yes
2	Post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and peridontally	35%	None	Yes	35%	None	Yes
2	Prefabricated and stainless steel crown	Once per tooth, per 60 months	35%	None	Yes	35%	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	35%	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, including intravenous and non-intravenous sedation	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; analgesia (nitrous oxide) is not covered with procedure codes D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	35%	None	Yes	35%	None	Yes
2	Recement cast or prefabricated post and core, inlay, crown		35%	None	Yes	35%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	35%	None	Yes	35%	None	Yes
2	Pulp vitality test		35%	None	Yes	35%	None	Yes
2	Diagnostic casts		35%	None	Yes	35%	None	Yes
3	Oral surgery, including postoperative care for:	Removal of teeth, except the surgical removal of 3rd molars	25%	None	Yes	25%	None	Yes
3	Oral surgery, including postoperative care for:	Extraction of tooth root or partial tooth	25%	None	Yes	25%	None	Yes
3	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, impacted teeth only, one per lifetime	25%	None	Yes	25%	None	Yes
3	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	25%	None	Yes	25%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy, once per lifetime per permanent tooth; retreatment of previous root canal therapy, once per lifetime, not within 24 months when done by same dentist or dental office	25%	None	Yes	25%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy and pulpal debridement; pulpal therapy; root amputation	25%	None	Yes	25%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy and periradicular surgery	25%	None	Yes	25%	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	25%	None	Yes
3	Periodontic services, limited to:	Four periodontal cleanings following surgery per calendar year after definitive periodontal therapy	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	Root scaling and planing, once per 24 months per quadrant	25%	None	Yes	25%	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:	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	25%	None	Yes
3	Periodontic services, limited to:	Gingivectomy, once per 24 months per quadrant	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 24 months per quadrant	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	Provisional splinting	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site per 36 months	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per 36 months	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	Bone replacement graft, once per quadrant, per 36 months	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	Guided tissue regeneration (natural teeth - resorbable and non-resorbable barriers, per site) and biologic materials to aid in osseous tissue regeneration	25%	None	Yes	25%	None	Yes
3	Periodontic services, limited to:	Soft tissue allograft, once per quadrant, per 36 months	25%	None	Yes	25%	None	Yes
3	Restoration services, limited to:	Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth 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	25%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures; repair of dentures; addition of teeth or clasp to existing partial denture	25%	None	Yes	25%	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	25%	None	Yes
3	Prosthetic services, limited to:	One relining of existing removable dentures; or rebonding or recementing fixed denture; per 24 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); Reline of custom sleep apnea appliance (indirect)	25%	None	Yes	25%	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:	Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months	25%	None	Yes	25%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning (not covered when performed within 6 months of any denture)	25%	None	Yes	25%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns, abutments, bridges, complete dentures, and/or partial dentures. Limited to 1 per tooth every 5 years.	25%	None	Yes	25%	None	Yes
3	Scaling and debridement in the presence of inflammation or mucositis of a single implant	One (1) per two (2) years, including cleaning of the implant surfaces, without flap entry and closure	25%	None	Yes	25%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		25%	None	Yes	25%	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	50%	None	Yes

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 as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
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, as determined by the Plan. 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.