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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 Plus (IN)
Coverage Schedule, Limitations and Exclusions for Adult Services

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	90%	None
2	Basic Services	50%	None	40%	None
3	Major Services	0%	N/A	0%	N/A
4	Orthodontic Services	0%	N/A	0%	N/A

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

- 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 and Class 2

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 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	100%	None	Yes	90%	None	Yes
1	Emergency or problem focused exam (D0140)	One per Calendar Year	100%	None	Yes	90%	None	Yes
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	100%	None	Yes	90%	None	Yes
1	Bitewing x-rays	Two per Calendar Year	100%	None	Yes	90%	None	Yes
1	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	Yes	90%	None	Yes
1	Periapical x-rays		100%	None	Yes	90%	None	Yes
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	Yes	90%	None	Yes
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	Yes	90%	None	Yes
2	Simple extraction of teeth		50%	None	Yes	40%	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	50%	None	Yes	40%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	50%	None	Yes	40%	None	Yes
2	Antibiotic injections administered by a dentist		50%	None	Yes	40%	None	Yes
2	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	None	Yes	40%	None	Yes
2	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	None	Yes	40%	None	Yes
2	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	None	Yes	40%	None	Yes
2	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	None	Yes	40%	None	Yes
2	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	50%	None	Yes	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	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		0%	N/A	N/A	0%	N/A	N/A
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal	One per tooth per lifetime	0%	N/A	N/A	0%	N/A	N/A
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	0%	N/A	N/A	0%	N/A	N/A
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		0%	N/A	N/A	0%	N/A	N/A
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: full mouth debridement	One per lifetime	0%	N/A	N/A	0%	N/A	N/A
3	Study model	One per 36 months	0%	N/A	N/A	0%	N/A	N/A
3	Crown build-up for non-vital teeth		0%	N/A	N/A	0%	N/A	N/A
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	0%	N/A	N/A	0%	N/A	N/A
3	Repair of dentures or fixed bridgework	One per 24 months	0%	N/A	N/A	0%	N/A	N/A
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	0%	N/A	N/A	0%	N/A	N/A
3	Infiltration of sustained release therapeutic drug, per quadrant		0%	N/A	N/A	0%	N/A	N/A
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	0%	N/A	N/A	0%	N/A	N/A

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: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	0%	N/A	N/A	0%	N/A	N/A
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	0%	N/A	N/A	0%	N/A	N/A
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	0%	N/A	N/A	0%	N/A	N/A
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		0%	N/A	N/A	0%	N/A	N/A
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	0%	N/A	N/A	0%	N/A	N/A
3	Prosthetic services, limited to: addition of teeth to existing partial denture		0%	N/A	N/A	0%	N/A	N/A
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)	0%	N/A	N/A	0%	N/A	N/A
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

The plan excludes and will not reimburse for the following services or charges:

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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions.
16. 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.
17. Treatment of cleft palate, malignancies or neoplasms.
18. 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").

DOMINION® NATIONAL DENTAL

Choice PPO Basic *Kids* (IN) 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	30%	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $200 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

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, pre-authorization is required.

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	One per six (6) months	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis/cleaning	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment, topical application	Two per twelve (12) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one set per six (6) months	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	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restoration	One per tooth per 36 months (limited to occlusal surfaces of permanent molar 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	Composite resin restorations limited to anterior teeth only; coverage for resins on posterior teeth is limited to the corresponding amalgam benefit	35%	None	Yes	20%	None	Yes
2	Pin retention of fillings	Per tooth, only in conjunction with a permanent amalgam or composite filling restoration	35%	None	Yes	20%	None	Yes
2	Crown build-up for non-vital teeth and cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	35%	None	Yes	20%	None	Yes
2	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown	Once per tooth, per 60 months; prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration	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	Emergency palliative treatment or after-hours office 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
2	General anesthesia and analgesic, including intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide	Must be administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant	35%	None	Yes	20%	None	Yes
2	Recement cast or prefabricated post and core, inlay or onlay, crown, bridge		35%	None	Yes	20%	None	Yes
2	Therapeutic parenteral drug administration		35%	None	Yes	20%	None	Yes
2	Diagnostic casts		35%	None	Yes	20%	None	Yes
3	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; excision of hyperplastic tissue, vestibuloplasty	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:	Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy and retreatment of previous root canal therapy	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, direct and indirect (includes sedative filling); pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation; hemisection, including any root removal	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy limited to primary teeth only	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	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	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Incomplete endodontic therapy, inoperable or fractured tooth	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	25%	None	Yes	10%	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/ periradicular surgery	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Four periodontal maintenance or prophylaxis following surgery per 12 months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant once per 36 months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 36 months per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Clinical crown lengthening - hard tissue	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Subepithelial connective tissue graft procedure	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Full mouth debridement, once per lifetime	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Bone replacement graft, once per 36 months when tooth is present	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery, once per 36 months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Surgical revision procedure, per tooth, once per 36 months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Guided tissue regeneration, once per 36 months when tooth is present	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:	Cast metal, resin-based or porcelain/ceramic inlay, onlay, and crown for permanent tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Labial veneers	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Crown, inlay, onlay and veneer repair	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to partial denture	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Simple stress breakers, per unit	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline full or partial denture limited to once per 36 months; denture rebases or relines done within 6 months are considered to be part of the denture placement when the rebase or reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 months after the insertion of the denture.	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	25%	None	Yes	10%	None	Yes
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	10%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	25%	None	Yes	10%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns and retainer for fixed partial denture, abutment supported crown and retainer for fixed partial denture, bridges, complete dentures, and/or partial dentures; implant/abutment supported removable denture for completely or partially edentulous arch, implant/abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 months	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	Implants and related services	Surgical placement of implant body, endosteal implant; surgical placement of eposteal or transosteal implant	25%	None	Yes	10%	None	Yes
3	Implants and related services	Radiographs/surgical implant index, limited to once per arch per 60 months	25%	None	Yes	10%	None	Yes
3	Implants and related services	Repair implant supported prosthesis, abutment and implant removal	25%	None	Yes	10%	None	Yes
3	Occlusal guards	Limited to one per 12 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, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion with prior authorization	50%	None	No	30%	None	No

Plan Exclusions

The plan excludes and will not reimburse for the following services or charges:

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. 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 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. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. 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.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.