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EXTENSIVE NETWORKS[2]

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

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

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

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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 (OR)
Coverage Schedule 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	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, Class 3	Class 1, Class 2, 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 adult member - maximum $150 for 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 and 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 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: 90% Y2: 90% Y3: 90%	None	Yes
1	Emergency or problem focused exam (D0140)	One per calendar year	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 90% Y2: 90% Y3: 90%	None	Yes
1	Prophylaxis (D1110 or D1120)	Two per calendar year	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 90% Y2: 90% Y3: 90%	None	Yes
1	Bitewing x-rays	Two per calendar year	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 90% Y2: 90% Y3: 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	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 90% Y2: 90% Y3: 90%	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: 90% Y2: 90% Y3: 90%	None	Yes
2	Simple extraction of teeth		Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 30% Y2: 50% 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% Y2: 60% Y3: 80%	None	Yes	Y1: 30% Y2: 50% Y3: 70%	None	Yes
2	Periapical x-rays		Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 30% Y2: 50% Y3: 70%	None	Yes
2	Full mouth or panoramic x-ray	One per 60 months	Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 30% Y2: 50% Y3: 70%	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: 30% Y2: 50% Y3: 70%	None	Yes
2	Antibiotic injections administered by a dentist		Y1: 50% Y2: 60% Y3: 80%	None	Yes	Y1: 30% Y2: 50% 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		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	None	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal	One per tooth per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	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: 10% Y2: 20% 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% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	None	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per calendar year following surgery	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	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: 10% Y2: 20% Y3: 40%	None	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	None	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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: pedicle or free soft tissue graft	One per site per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	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: 10% Y2: 20% Y3: 40%	None	Yes
3	Periodontic services, limited to: full mouth debridement	One per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	None	Yes
3	Study model	One per 36 months	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	None	Yes
3	Crown build-up for non-vital teeth		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	None	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	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: 10% Y2: 20% Y3: 40%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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, per permanent tooth per patient	Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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	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: 10% Y2: 20% Y3: 40%	None	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	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: 10% Y2: 20% Y3: 40%	None	Yes
3	Prosthetic services, limited to: addition of teeth to existing partial denture		Y1: 15% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% 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% Y2: 25% Y3: 50%	None	Yes	Y1: 10% Y2: 20% Y3: 40%	None	Yes
4	Orthodontia Services	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	None	N/A	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. 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 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, malignancies or neoplasms.
17. 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* (OR)
Coverage Schedule 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	Two (D0120, D0145, D0150, D0160, or D0180) per twelve (12) months; coverage for all evaluations by medical practitioners who are oral surgeons	100%	None	No	80%	None	No
1	Limited evaluations	Limited evaluation or re-evaluation, problem focused (D0140 or D0170) do not count against annual exam frequency limitation	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months (additional topical fluoride treatments may be available when high risk conditions or oral health factors are present)	100%	None	No	80%	None	No
1	Bitewing x-rays	Four per six (6) months	100%	None	No	80%	None	No
1	Periapical x-rays	Limited to six (6) films per 12 months under age six (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 36 months (starting at age six)	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 maintainers	Covers fixed and removable space maintainers 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 (cannot be billed by the provider or practice that placed the appliance)	100%	None	No	80%	None	No
1	Sealants	One per tooth, per 60 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

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	Amalgam and composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; includes occlusal adjustment and polishing of restoration; protective restorations when not billed on the same day as a normal restoration	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	Crown build-up	Covered for non-vital teeth	35%	None	Yes	20%	None	Yes
2	Post and core	Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	35%	None	Yes	20%	None	Yes
2	Prefabricated crowns	One per tooth per 60 months	35%	None	Yes	20%	None	Yes
2	Temporary crowns	Covered for a fractured tooth	35%	None	Yes	20%	None	Yes
2	Emergency palliative treatment	Emergency palliative treatment; the use of a house/extended care facility call (D9410) is available for urgent or emergent dental visits that occur outside of a dental office	35%	None	Yes	20%	None	Yes
2	General anesthesia and analgesic, including intravenous and non-intravenous sedation	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	20%	None	Yes
2	Occlusal guard	Coverage with covered surgery, by report	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	Re-cement cast or prefabricated post and core, inlay, crown		35%	None	Yes	20%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	35%	None	Yes	20%	None	Yes
3	Oral surgery, including postoperative care for:	Removal of teeth except the surgical removal of third molars; includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction (surgical removal of impacted teeth or removal of residual tooth roots limited to teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums)	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Extraction of tooth root or partial tooth	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Excision of periocoronal gingiva or hyperplastic 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:	Incision and drainage of an abscess or cyst	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Biopsy of oral tissue (D7285, D7286)	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 permanent tooth (not covered for third molars); retreatment of previous root canal therapy, on anterior teeth, one per lifetime, not within 24 months when done by same dentist or dental office	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:	Pulp cap; pulpotomy and pulpal debridement, pulpal therapy and regeneration; apexification/ recalcification (endodontists only); apicoectomy; retrograde fillings	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	One periodontal cleaning following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years, per six months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Root scaling and planing, once per quadrant, per 24 months	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 D1120/D1110, limited to once per two years	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingivectomy/ gingivoplasty (D4210/ D4211), limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site, per lifetime	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	One full mouth debridement per 24 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	Restoration services, limited to:	Cast metal, stainless steel, 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; permanent crown replacement limited to once every seven years and all other crown replacements limited to once every five years; stainless steel crowns (D2930/D2931) allowed only for anterior primary and posterior permanent or primary teeth; prefabricated stainless steel crowns (D2933) allowed only for anterior teeth, permanent and porcelain fused to metal crowns limited to teeth numbers 6-11, 22 and 27 only; members age 16 through 18; includes preparation of gingival tissue	25%	None	Yes	10%	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 (1) per two (2) years	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures; members age 16 and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140); includes adjustments during six-month period following delivery	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures	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	Prosthetic services, limited to:	Replacement of removable partial or full dentures that cannot be repaired for members at least 16 and under 19; shall replace full every 10 years or partial dentures once every 5 years from the date of last placement; interim partial dentures or flippers (D5820-D5821) covered if the member has one or more anterior teeth missing and are covered once per five years when dentally appropriate	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Addition of teeth or clasp to existing partial denture	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	One relining or rebasing of existing removable dentures; or rebonding or recementing fixed denture; per 36 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); laboratory relines are not covered prior to six months after placement of an immediate denture and are limited to once per 36 months; rebases covered only if a reline may not adequately solve the problem; exceptions to this limitation may be made in the event of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This includes, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for these conditions (severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing)	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	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:	Fluoride gel carrier for patients with severe oral disease	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning (not covered when performed within 6 months of any denture)	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 or members with the ICD-10-CM diagnosis of cleft palate or cleft palate with cleft lip	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, with the exception of dental emergencies.
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 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.