

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



## Elite PPO Premium 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 <sup>1</sup>	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	None
Annual Deductible		In-Network		Out-of-Network	
Single Child		\$50		\$50	
Two or More Children		\$100		\$100	
Applies To		Class 2 and Class 3		Class 2 and Class 3	
<ul style="list-style-type: none"><li>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 \$100 for pediatric members.</li></ul>					
Out-of-Pocket Maximums		In-Network		Out-of-Network	
Single Child		\$450		N/A	
Two or More Children		\$900		N/A	
<ul style="list-style-type: none"><li>The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.</li></ul>					
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	Prevention Rewards	Primary subscriber will receive a \$20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist	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	Interim 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, D1525 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)	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	None	Yes	60%	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	80%	None	Yes	60%	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	80%	None	Yes	60%	None	Yes
2	Occlusal guard	Analysis and limited/complete adjustment, one in 12 months for patients 13 and older, by report	80%	None	Yes	60%	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	80%	None	Yes	60%	None	Yes
2	Addition of teeth to existing partial denture		80%	None	Yes	60%	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)	80%	None	Yes	60%	None	Yes
2	Repair of crowns, dentures and bridges	Twice per year and five total per 5 years	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, and frenectomy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of periocoronary gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	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	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, impacted teeth only, one per lifetime	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy; apicoectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, one per root per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Periodontal cleanings, two per calendar year, in addition to adult prophylaxis, within 24 months after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, once per 24 months per quadrant per patient	80%	None	Yes	60%	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 D1110/ D1120, limited to once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, once per 36 months per patient, per quadrant and gingival irrigation with a medicinal agent, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 36 months per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle or free soft tissue graft, one per site per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per lifetime	80%	None	Yes	60%	None	Yes
3	Study model	One per 36 months	50%	None	Yes	30%	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	50%	None	Yes	30%	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; placement of interim direct restoration; post removal; crown buildup for non-vital teeth	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after 5 years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction of bridges, replacement limited to once per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Replacement of implant crowns limited to once per 60 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	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.

- Services which are covered under worker's compensation or employer's liability laws.
- Services which are not necessary for the patient's dental health.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
- Oral surgery requiring the setting of fractures or dislocations.
- 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.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- 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.
- Replacement due to loss or theft of prosthetic appliance.
- Services related to the treatment of TMD (Temporomandibular Disorder).
- 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.
- Services not listed as covered.
- Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
- 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.
- 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.
- Treatment of cleft palate (if not treatable through orthodontics), malignancies or neoplasms.
- 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.

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



## Elite PPO Premium Kids (DE) 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 <sup>1</sup>	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	None
Annual Deductible		In-Network		Out-of-Network	
Single Child		\$50		\$50	
Two or More Children		\$100		\$100	
Applies To		Class 2 and Class 3		Class 2 and Class 3	
<ul style="list-style-type: none"><li>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 \$100 for pediatric members.</li></ul>					
Out-of-Pocket Maximums		In-Network		Out-of-Network	
Single Child		\$450		N/A	
Two or More Children		\$900		N/A	
<ul style="list-style-type: none"><li>The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.</li></ul>					
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 required.

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	80%	None	No
1	Limited evaluation or re-evaluation, problem focused	One (D0140 or D0170) per twelve (12) months	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	80%	None	No
1	Prevention Rewards	Primary subscriber will receive a \$20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Four films per six (6) month	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 36 months	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 fixed space maintainer (D1510, D1516, D1517) per 5 years, per arch to age 14, 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); one distal shoe space maintainer (D1575), fixed, unilateral per lifetime.	100%	None	No	80%	None	No
1	Sealants	One per tooth per 60 months, to age 16 (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 24 months (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations); placement of interim direct restorations when not billed on the same day as a normal restoration	80%	None	Yes	60%	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	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	None	Yes	60%	None	Yes
2	Crown build-up	Coverage for non-vital teeth	80%	None	Yes	60%	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 periodontally	80%	None	Yes	60%	None	Yes
2	Prefabricated crowns	One per tooth, per 60 months	80%	None	Yes	60%	None	Yes
2	Temporary crowns for a fractured tooth		80%	None	Yes	60%	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	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous and nonintravenous sedation	Maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure code D9230, D9239 or D9243; intravenous conscious sedation is not covered with procedure code D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure code D9222, D9223 or D9230; analgesia (nitrous oxide) is not covered with procedure code D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	80%	None	Yes	60%	None	Yes
2	Occlusal guard	One per 24 months with covered surgery	80%	None	Yes	60%	None	Yes
2	Recent cast or prefabricated post and core, inlay, crown		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth except the surgical removal of 3rd molars	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root or partial tooth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty, limited to ages 14-18	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of pericoronal gingiva or hyperplastic tissue and excision of oral tissue for biopsy, limited to ages 14-18	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	Yes	60%	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	Oral surgery, including postoperative care for:	Incision and drainage of an abscess or cyst, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Biopsy of oral tissue (D7285, D7286)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Mobilization of erupted or malpositioned tooth, covered for all teeth except 3rd molars	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Placement of device to facilitate eruption of impacted tooth (indicate if orthodontia related)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Sutures, limited to ages 14-18	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy and pulpal debridement; pulpal therapy and regeneration	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification (endodontists only), limited to ages 6-16; apicoectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, per root, per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Two periodontal cleanings following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One (1) scaling and root planing per quadrant, per 24 months	80%	None	Yes	60%	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 once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, once per quadrant, per 24 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per quadrant, per 24 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site	80%	None	Yes	60%	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	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Mesial/distal wedge procedure, single tooth	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Soft tissue allograft	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel, provisional, porcelain/ceramic, all ceramic and resin-based composite 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	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures twice per year, and five total per 5 years	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after 5 years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	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)	50%	None	Yes	30%	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	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Obturator prosthesis and modification, mandibular resection prosthesis or trismus appliance	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Fluoride and/or topical medication carrier for patients undergoing radiation treatment	50%	None	Yes	30%	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:	Tissue conditioning (not covered when performed within 6 months of any denture)	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	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%	N/A	N/A

### Plan Exclusions

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

- Services which are covered under worker's compensation or employer's liability laws.
- Services which are not necessary for the patient's dental health as determined by the Plan.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
- Oral surgery requiring the setting of fractures or dislocations.
- 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.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- 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.
- Replacement due to loss or theft of prosthetic appliance.
- Services related to the treatment of TMD (Temporomandibular Disorder).
- 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.
- Services not listed as covered.
- Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
- 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.
- 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.
- Treatment of cleft palate (if not treatable through orthodontics), malignancies or neoplasms.
- 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.

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



## Elite PPO Premium Kids (MD) 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 <sup>1</sup>	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	30%	None
Annual Deductible		In-Network		Out-of-Network	
Single Child		\$50		\$50	
Two or More Children		\$100		\$100	
Applies to		Class 2 and Class 3		Class 2 and Class 3	
<ul style="list-style-type: none"><li>Each member must pay the 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 \$100 per Calendar Year at which point the deductible is waived for remaining pediatric members.</li></ul>					
Out-of-Pocket Maximums		In-Network		Out-of-Network	
Single Child		\$450		N/A	
Two or More Children		\$900		N/A	
<ul style="list-style-type: none"><li>The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.</li></ul>					
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 (D0120, D0145, D0150 or D0160) per calendar year, per patient per provider/ location	100%	None	No	80%	None	No
1	Re-evaluation, limited, problem focused (D0170) or periodontal exam (D0180)	One per calendar year	100%	None	No	80%	None	No
1	Limited oral evaluation (D0140)		100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	Two per calendar year, per patient	100%	None	No	80%	None	No
1	Prevention Rewards	Primary subscriber will receive a \$20 payment from Dominion for each family member that receives two cleanings during the calendar year from a participating Elite PPO network dentist	100%	None	No	80%	None	No
1	Fluoride treatments	One (1) topical fluoride application (D1208) is covered two (2) times per calendar year, per patient; four (4) topical fluoride varnish treatments (D1206) are covered per calendar year, per patient for children age three (3) and above; eight (8) topical fluoride varnish treatments (D1206) are covered per calendar year, per patient up to age two (2).	100%	None	No	80%	None	No
1	Bitewing x-rays	Two per calendar year, starting at age two, per provider/location (D0270 does not have a frequency limitation)	100%	None	No	80%	None	No
1	Periapical x-rays		100%	None	No	80%	None	No
1	Full mouth x-ray or panoramic film	One per 36 months starting at age six; maximum of one set of x-rays per provider/ location	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	One per 24 months, per quadrant (D1510, D1520 or D1575) or per arch (D1516, D1517, D1526 or D1527), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment). Re-cement or re-bond bilateral or unilateral space maintainer (D1551, D1552 or D1553) not covered within 6 months of initial placement. Removal of fixed unilateral and bilateral space maintainer (D1556, D1557 or D1558) not allowed by dental office that provided initial placement.	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?
1	Sealants	One per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	100%	None	No	80%	None	No
1	Other diagnostic imaging (D0290, D0310, D0320, D0321)		100%	None	No	80%	None	No
1	2D cephalometric radiographic image (D0340) or image capture (D0702)	One per 36 months per patient	100%	None	No	80%	None	No
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	100%	None	No	80%	None	No
1	Pulp vitality tests		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
1	Consultations (D9310)		100%	None	No	80%	None	No
1	House/extended care facility calls		100%	None	No	80%	None	No
1	Application of desensitizing medicament	One per visit. Not to be used for bases, liners or adhesives used under restorations	100%	None	No	80%	None	No
2	Amalgam and resin-based composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; per tooth, per surface every 36 months	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	None	Yes	60%	None	Yes
2	Hospital call	Facility and anesthesia charges are covered and covered under medical insurance; services delivered to the patient on the date of service are documented separately using applicable procedure codes; requires coordination and approval from both the dental insurer and the medical insurer before services can be rendered	80%	None	Yes	60%	None	Yes
2	Occlusal guard		80%	None	Yes	60%	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	80%	None	Yes	60%	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	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root or partial tooth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, one (1) per tooth, impacted teeth only, per lifetime	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of pericoronal gingiva or hyperplastic tissue and excision of oral tissue for biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation; Surgical repositioning of teeth, one per lifetime per patient per tooth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of a benign lesion, tumor or cyst and incision and drainage of an abscess or cyst, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Biopsy of oral tissue (D7285, D7286)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of exostosis (D7471), torus palatinus (D7472), and torus mandibularis (D7473)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Partial ostectomy/ sequestrectomy for removal of non-vital bone	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy once per lifetime, per patient, per tooth; Retreatment of previous root canal therapy, one per tooth, per lifetime, not within 24 months when done by same dentist or dental office	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy; pulpal debridement; pulpal therapy; pulpal regeneration; apexification/ recalcification; apicoectomy; pulp caps (D3110 and D3120); root amputation (resection); hemisection	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical repair of root resorption (D3471, D3472 and D3473) and surgical exposure of root surfaces without apicoectomy or repair of root resorption (D3501, D3502 and D3503)	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, per root per lifetime	80%	None	Yes	60%	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	Periodontic services, limited to:	Two periodontal maintenance visits following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Unscheduled dressing change (by someone other than treating dentist or their staff)	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, once per 24 months, per patient, per quadrant	80%	None	Yes	60%	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 once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Occlusal adjustment, limited, if provided when no other restorative procedure on same date of service, limited to twice per twelve (12) months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Occlusal adjustment, complete, if provided when no other restorative procedure on same date of service, limited to once per twelve (12) months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months, per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including root planing (D4240 and D4241), 1-3 or 4+ contiguous teeth or tooth-bounded spaces, one per 24 months per patient per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Anatomical crown exposure and clinical lengthening	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 24 months, per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Splint-intracoronary; natural teeth or prosthetic crowns (D4322); Splint-extra-coronal; natural teeth or prosthetic crowns (D4323)	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle or free soft tissue graft per site, per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per 24 months	80%	None	Yes	60%	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	Periodontic services, limited to:	Localized delivery of antimicrobial agents is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per 12 months (must have pocket depths of five millimeters or greater)	80%	None	Yes	60%	None	Yes
3	Study model	One per 36 months	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel, porcelain/ceramic, all ceramic, titanium and resin-based composite inlay, onlay, or crown for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; replacement of inlays, onlays and crowns limited to one per 60 months from the original date of placement, per permanent tooth, per patient; pre-fabricated crowns are limited to one per 36 months per permanent tooth (D2928, D2929), per primary tooth (D2930, D2934) and per primary or permanent tooth (D2932, D2933)	50%	None	Yes	30%	None	Yes
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	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Placement of interim direct restoration	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Post removal	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Core build-up one (1) per 60 months per tooth	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	One labial veneer per 60 months, per tooth	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Re-cement crowns/inlays	50%	None	Yes	30%	None	Yes
3	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	One (1) per two (2) years	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures after five years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Addition of teeth or clasp to existing partial denture per tooth	50%	None	Yes	30%	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:	Relining or rebasing of existing removable dentures; rebonding or recementing fixed denture; Reline of custom sleep apnea appliance (indirect)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Adjust complete or partial denture, not covered within 6 months of initial placement.	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Adjustment and maintenance of maxillofacial prosthetics, limited to D5992 and D5993, one each per patient, per six months, per arch	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Overdenture, one (1) D5863, D5864 or D5865 per 60 months, per patient	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Fabrication of athletic mouthguard	50%	None	Yes	30%	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; Replacement of lost or broken retainer (D8703 or D8704), one per arch per lifetime, allowed within 24 months of date of debanding	50%	None	No	30%	None	No

#### Plan Exclusions

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

- Services which are covered under worker's compensation or employer's liability laws.
- Services which are not necessary for the patient's dental health.
- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
- Oral surgery requiring the setting of fractures or dislocations.
- Dispensing of drugs.
- Hospitalization for the following: the operation or treatment for the fitting or wearing of dentures; orthodontic care or malocclusion, operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for the removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and dental implants.
- 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.
- Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
- Services not listed as covered.
- 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.
- Treatment of cleft palate (if not treatable through orthodontics) or neoplasms.
- 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.

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



## Elite PPO Premium Kids (PA) 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 <sup>1</sup>	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	None
Annual Deductible		In-Network		Out-of-Network	
Single Child		\$50		\$50	
Two or More Children		\$100		\$100	
Applies To		Class 2 and Class 3		Class 2 and Class 3	
<ul style="list-style-type: none"><li>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 \$100 for pediatric members.</li></ul>					
Out-of-Pocket Maximums		In-Network		Out-of-Network	
Single Child		\$450		N/A	
Two or More Children		\$900		N/A	
<ul style="list-style-type: none"><li>The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.</li></ul>					
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 (1) evaluation (D0120, D0140, D0150 or D0180) per six (6) months, per patient; D0160 is covered.	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One (1) per six (6) months, per patient	100%	None	No	80%	None	No
1	Prevention Rewards	Primary subscriber will receive a \$20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist	100%	None	No	80%	None	No
1	Fluoride treatment	One (1) per six (6) months, per patient	100%	None	No	80%	None	No
1	Bitewing x-rays	One (1) 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 (1) per 60 months; maximum of one (1) 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 (D1516, D1517, D1526 or D1527)	To preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); D1575 limited to one (1) per 24 months	100%	None	No	80%	None	No
1	Sealants	One (1) 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	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one (1) pin	80%	None	Yes	60%	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	80%	None	Yes	60%	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 code D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure code D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	80%	None	Yes	60%	None	Yes
2	Occlusal guard	Analysis and limited/complete adjustment, one (1) in 12 months for patients 13 and older, by report	80%	None	Yes	60%	None	Yes
2	Prefabricated stainless steel or porcelain crown	One (1) 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	80%	None	Yes	60%	None	Yes
2	Addition of teeth to existing partial denture		80%	None	Yes	60%	None	Yes
2	Relining or rebasing of existing removable dentures	One (1) per 36 months; only after six (6) months from date of last placement, unless an immediate prosthesis replacing at least three (3) teeth	80%	None	Yes	60%	None	Yes
2	Repair of crowns, dentures and bridges		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, impacted teeth only, one per lifetime	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, and frenectomy	80%	None	Yes	60%	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	Oral surgery, including postoperative care for:	Excision of periocoronary gingiva, exostosis or hyperplastic tissue, and excision of oral tissue for biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy; apicoectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, one (1) per root per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Two (2) periodontal cleanings, in addition to adult prophylaxis, per calendar year, within 24 months after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, one (1) per 24 months, per quadrant, per patient	80%	None	Yes	60%	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 D1110/ D1120, limited to one (1) per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, one (1) per 36 months per patient, per quadrant; gingival irrigation with a medicinal agent, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, one (1) per 36 months per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle or free soft tissue graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one (1) per lifetime	80%	None	Yes	60%	None	Yes
3	Study model	One (1) per 36 months	50%	None	Yes	30%	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, 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 (1) per 60 months from the original date of placement, per permanent tooth, per patient	50%	None	Yes	30%	None	Yes
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; placement of interim direct restoration; post removal; crown buildup for non-vital teeth	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after five (5) years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction of bridges, replacement limited to one (1) per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Replacement of implant crowns limited to one (1) in 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	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%	N/A	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.

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



## Elite PPO Premium Kids (VA) 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 <sup>1</sup>	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	None
Annual Deductible		In-Network		Out-of-Network	
Single Child		\$50		\$50	
Two or More Children		\$100		\$100	
Applies To		Class 2 and Class 3		Class 2 and Class 3	
<ul style="list-style-type: none"><li>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 \$100 per Calendar Year at which point the deductible is waived for remaining pediatric members.</li><li>The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.</li></ul>					
Maximum Out-of-Pocket (MOOP)		In-Network		Out-of-Network	
Single Child		\$450		N/A	
Two or More Children		\$900		N/A	
<ul style="list-style-type: none"><li>The MOOP applies to all covered services for medically necessary treatment.</li><li>The MOOP applies per covered child through the end of the year in which the child turns 19. A family with 2 or more covered children will have an aggregate MOOP of \$900 for all children with no child contributing more than the single child MOOP.</li></ul>					
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 (D0120, D0145 or D0150) per six (6) months, per patient	100%	None	No	80%	None	No
1	Re-evaluation, limited or problem focused	One exam per six (6) months, per patient	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	Prevention Rewards	Primary subscriber will receive a \$20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist	100%	None	No	80%	None	No
1	Fluoride treatments	One per six (6) months, per patient	100%	None	No	80%	None	No
1	Bitewing x-rays		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 x-rays		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	One per 24 months, per quadrant (unilateral) or per arch (bilateral), per patient 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); D1575 limited to once per 24 months	100%	None	No	80%	None	No
1	Sealants	One per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	100%	None	No	80%	None	No
1	Diagnostic cast		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	Per tooth, per surface every 12 months	80%	None	Yes	60%	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	80%	None	Yes	60%	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	Local anesthesia; general anesthesia and analgesic, including intravenous and non-intravenous sedation	Maximum of 150 minutes or 10 units of general anesthesia and sedation allowed; requires a narrative of medical necessity be maintained in patient records. The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment	80%	None	Yes	60%	None	Yes
2	Hospital call	Facility and anesthesia charges are considered medical services; services delivered to the patient on the date of service are documented separately using applicable procedure codes; requires coordination and approval from both the dental insurer and the medical insurer before services can be rendered	80%	None	Yes	60%	None	Yes
2	Occlusal guard	For grinding and clenching of teeth, by report	80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim; desensitizing medicaments	80%	None	Yes	60%	None	Yes
2	Consultations	When not performed by another dentist within the same facility and not in conjunction with orthodontia	80%	None	Yes	60%	None	Yes
2	Prefabricated crowns	Once per tooth, per 36 months	80%	None	Yes	60%	None	Yes
2	Temporary crowns	Coverage only for a fractured tooth	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	None	Yes	60%	None	Yes
2	Crown build-up	Coverage for non-vital teeth	80%	None	Yes	60%	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 periodontally	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core; recement crown		80%	None	Yes	60%	None	Yes
2	Placement of interim direct restoration		80%	None	Yes	60%	None	Yes
2	Labial veneer	One (1) per 60 months, per tooth (will be considered as an alternative to a full restoration for an endodontically treated tooth)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root or partial tooth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, impacted teeth only, one (1) per lifetime	80%	None	Yes	60%	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	Oral surgery, including postoperative care for:	One (1) alveoplasty per quadrant per patient per lifetime; one (1) frenulectomy or frenuloplasty per patient per lifetime	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of periocoronal gingiva or hyperplastic tissue and excision of oral tissue for biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of a benign lesion, tumor or cyst and incision and drainage of an abscess or cyst, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of oral tissue, odontogenic cyst, torus palatinus and mandibularis (D7285, D7286)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Oroantral fistula closure and primary closure of a sinus perforation	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Occlusal orthotic device for TMJ (D7880)	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy, once per permanent tooth, per lifetime, per patient; retreatment of previous root canal therapy, once per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy and pulp cap; pulpal therapy and pulpal debridement; pulpal regeneration	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification limited to one (1) per tooth per provider, per lifetime; D3352 limited to three (3) treatments per tooth, per provider, per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Periradicular surgery without apicoectomy, one per tooth, per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apicoectomy, one (1) per tooth, per patient, per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, per root, per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal cleanings following surgery per 12 months after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One (1) scaling and root planing, per 24 months, per quadrant, per patient	80%	None	Yes	60%	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	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	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Occlusal adjustment performed with covered surgery	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months, per quadrant, per patient and gingival irrigation with a medicinal agent, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 60 months, per quadrant, per patient	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Splint – intra-coronal and extra-coronal	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle, subepithelial, bone replacement or free soft tissue graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one (1) per 12 months, only covered when there is substantial gingival inflammation in all four (4) quadrants	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal crown, porcelain/ceramic crown, porcelain/ceramic onlay, all ceramic crown and resin-based composite onlay (D2644). Requires documentation of medical necessity. One per 60 months from the original date of placement, per permanent tooth, per patient	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete or partial dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Immediate denture, one per arch per lifetime per patient	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures; rebonding or recementing fixed denture; denture adjustment	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of complete or partial dentures that cannot be repaired after five (5) years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	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:	One (1) relining or rebasing of existing removable dentures per 24 months (only after six (6) months from date of last placement)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Feeding aid (D5951)	50%	None	Yes	30%	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	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recement fixed partials as needed	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Pontics, retainer inlays, retainer onlays and retainer crowns, one per 60 months per patient per tooth	50%	None	Yes	30%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable and fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting), replacement of lost or broken retainer (D8692), and comprehensive therapy; Orthodontia services limited to once per lifetime and are only provided for severe, dysfunctional, handicapping malocclusion.	50%	None	No	0%	None	No

### 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. 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) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires medically necessary orthodontia services or an occlusal orthotic device, by report, for temporomandibular pain, dysfunction or associated musculature.
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 and replacing tooth structure lost by attrition.
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 (if not treatable through orthodontics), malignancies or neoplasms.
17. Orthodontics is only covered if medically necessary. 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, including pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, one set of retainers and 12 months of retainer adjustments. Additional costs incurred will become the patient's responsibility subject to the annual out-of-pocket maximum.