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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 (NJ) Coverage Schedule, Limitations and Exclusions for Adult Services

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[2]	Waiting Period
		Y1|Y2|Y3[1]		Y1|Y2|Y3[1]	
1	Diagnostic & Preventive Services	100%|100%|100%	None	90%|90%|90%	None
2	Basic Services	50%|60%|80%	None	30%|50%|70%	None
3	Major Services	30%|40%|50%	None	25%|30%|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.

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

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

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

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

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

Out-of-Network Allowance	
	Maximum Allowable Charge

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

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

Plan will pay either the Participating Dentist's In-Network Allowed Amount or the Out-of-Network 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 maximum 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 (cleaning, scaling and polishing teeth)	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	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service. Out-of-network emergency palliative treatment is covered at the same cost share as if the Member visited a Participating Dentist	Y1: 100% Y2: 100% Y3: 100%	None	Yes	Y1: 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 Participating 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; marsupialization of odontogenic cyst		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% 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: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% 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: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One per lifetime	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% 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: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Study model	One per 36 months	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Crown build-up for non-vital teeth		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% 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: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% 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: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% 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: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	One per two years	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Prosthetic services, limited to: replacement of removable dentures or fixed bridges	That cannot be repaired after 7 years from the date of last placement	Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
3	Prosthetic services, limited to: addition of teeth to existing partial denture		Y1: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% 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: 30% Y2: 40% Y3: 50%	None	Yes	Y1: 25% Y2: 30% Y3: 40%	None	Yes
4	Orthodontia Services Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not Necessary and Appropriate Dental Services for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth including third molars.
12. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
13. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions, except for the Necessary Care and Treatment of medically diagnosed congenital defects and birth abnormalities.
14. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
15. Any service or supply rendered to replace a tooth lost prior to the the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

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

DOMINION® NATIONAL DENTAL

Choice PPO Basic *Pediatric* (NJ) Coverage Schedule, Service Limitations and Exclusions for Pediatric Services

- Coverage continues through end of the year in which the member turns 19 -

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

Services in Class 1 - Class 4 are listed on p. 2 - 7 of this document

Annual Deductible	In-Network	Out-of-Network
Single Member	$100	$100
Two or More Members	$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 Member - maximum $200 for Members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Member	$400	N/A
Two or More Members	$800	N/A

- The annual Out-of-Pocket Maximum applies to all covered services for Necessary and Appropriate Dental Services.

Out-of-Network Allowance	
	Maximum Allowable Charge

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

- If course of treatment is to exceed $300, pre-authorization is required.

Plan will pay either the Participating Dentist's In-Network Allowed Amount or the Out-of-Network 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 evaluations (D0120, D0145, D0150, D0160 or D0180) per twelve (12) months	100%	None	No	80%	None	No
1	Limited evaluation or re-evaluation, problem focused	One (D0140, D0170 or D0171) per six (6) months	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	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 film (D0210 or D0330)	One every three (3) years	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	Intraoral, extraoral and other radiographic or photographic images (D0240, D0250, D0251, D0340, D0350)		100%	None	No	80%	None	No
1	Space maintainers	Fixed and removable space maintainer (D1510, D1516, D1517, D1520, D1526 and D1527) per arch 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	Professional visits/calls for observations, consultations & behavior mgmt - office, house, hospital or other inpatient/ outpatient facility		100%	None	No	80%	None	No
1	Cone beam images; Maxillofacial images, ultrasounds and MRIs		100%	None	No	80%	None	No
1	Diagnostic tests and examinations, including collection, preparation, accession, processing and analysis of viral cultures, samples and smears		100%	None	No	80%	None	No
1	Caries risk assessment and documentation		100%	None	No	80%	None	No
1	Diagnostic imaging with interpretation		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	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	80%	None	No
2	Amalgam and composite fillings; gold foil; protective restorations when not billed on the same day as a normal restoration	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations	35%	None	Yes	20%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	35%	None	Yes	20%	None	Yes
2	Crown build-up	Coverage for non-vital teeth	35%	None	Yes	20%	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	35%	None	Yes	20%	None	Yes
2	Prefabricated crowns; temporary crowns for a fractured tooth		35%	None	Yes	20%	None	Yes
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service. Out-of-network emergency palliative treatment is covered at the same cost share as if the Member visited a Participating Dentist	35%	None	Yes	35%	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	35%	None	Yes	20%	None	Yes
2	Athletic mouthguard; occlusal guard	Including limited and complete adjustments	35%	None	Yes	20%	None	Yes
2	Recement cast or prefabricated post and core, inlay, crown		35%	None	Yes	20%	None	Yes
2	Administration/application of therapeutic parenteral drug, other drugs and/or medicaments administration	Note medication on claim	35%	None	Yes	20%	None	Yes
2	Other oral pathology procedures, by report		35%	None	Yes	20%	None	Yes
2	Coping		35%	None	Yes	20%	None	Yes
3	Oral surgery, including postoperative care for:	Removal of teeth except the surgical removal of 3rd molars	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

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:	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, marsupialization of odontogenic cyst	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Mobilization of erupted or malpositioned tooth, covered for all teeth except 3rd molars	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Placement of device to facilitate eruption of impacted tooth (indicate if orthodontia related)	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Exfoliative cytological sample collection	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Radical resection of maxilla or mandible	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Other oral surgery procedures and related services	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; retreatment of previous root canal therapy; treatment for root canal obstruction, incomplete therapy and internal root repair of perforation, not within 24 months when done by same Participating Dentist or dental office	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy and pulpal debridement; pulpal therapy and regeneration	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification (endodontists only); apicoectomy; periradicular surgery; root amputation; hemisection	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical procedure for isolation of tooth with rubber dam	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Canal prep and fitting of preformed dowel or post	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Two periodontal cleanings following surgery per calendar year after definitive periodontal therapy	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	One (1) scaling and root planing per quadrant, per six (6) 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	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	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingivectomy or gingivoplasty	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingival flap procedure, including root planing - 1-3 or 4+ contiguous teeth or tooth-bounded spaces, per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Osseous surgery including flap entry and closure	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Pedicle, free soft tissue, subepithelial connective tissue, combined connective tissue or double pedicle graft per site	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per lifetime	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Bone replacement graft	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Guided tissue regeneration (natural teeth - resorbable and non-resorbable barriers, per site) and biologic materials to aid in osseous tissue regeneration	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Distal or proximal wedge procedure	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Soft tissue allograft	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Apically positioned flap	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Clinical crown lengthening	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Biologic materials to aid soft and osseous tissue regeneration	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Surgical revision	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Provisional splinting	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Localized delivery of antimicrobial agents	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite crown; inlay/onlay restorations for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; crown repair; study model (diagnostic cast); post removal	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Pediatric partial denture including removable unilateral partial dentures/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:	Repair of dentures; replacement of dentures that cannot be repaired; 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 12 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); reline of custom sleep apnea appliance (indirect)	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Obturator prosthesis and modification, mandibular resection prosthesis or trismus appliance	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Fluoride and/or topical medication carrier for patients undergoing radiation treatment; radiation carrier, shield and cone locator	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Precision attachment	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Palatal Prosthesis (palatal augmentation, palatal lift prosthesis - definitive, interim and modification)	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Commissure and surgical splints and stents	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Other maxillofacial prosthetics including adjustments and appliance removal	25%	None	Yes	10%	None	Yes
3	Implants and related services		25%	None	Yes	10%	None	Yes
3	Odontoplasty		25%	None	Yes	10%	None	Yes
3	Internal bleaching		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?
4	Orthodontia Services:	Orthodontic treatment requires pre-authorization and is not considered for cosmetic purposes. Orthodontic consultation can be provided once annually as needed by the same provider. Preorthodontic treatment visit for completion of the HLD (NJMod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services. Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or Participating Dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service. Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday. Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment. The placement of the appliance represents the treatment start date. Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires preauthorization. Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.	50%	None	No	0%	N/A	N/A

Plan Exclusions

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not Necessary and Appropriate Dental Services for the patient's dental health.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
4. 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.
5. 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.
6. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
7. 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 Necessary and Appropriate Dental Services.
8. 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.
9. Treatment of cleft palate, malignancies or neoplasms, except in the case of newborn children or the Necessary Care and Treatment of medically diagnosed congenital defects and birth abnormalities.
10. Orthodontics is only covered as a Necessary and Appropriate Dental Service as determined by the Plan. The Invisalign system and similar specialized braces are not a covered service.