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## A Better Path to Benefits



Dominion National recognizes that you're a unique individual and we've designed plans and programs that work for you. We seek a better way to serve you through customized plans and exceptional service so that you can focus on what makes you extraordinary and fulfilled.

## WE WORK FOR THE BENEFIT OF OUR MEMBERS, DELIVERING:

### EXTENSIVE NETWORKS<sup>2</sup>

Choice PPO network offers access to over 350,000 dentists nationally.<sup>1,3</sup>

Elite PPO and Elite ePPO networks provide unmatched flexibility and lower out-of-pocket costs.

Select Plan network is one of the largest in the Mid-Atlantic region.<sup>3,4</sup>

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

### SECURE ONLINE ACCESS

Access your digital ID card, find a provider and more through secure online resources.



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Eligibility and claim information are available for members, benefit administrators and dentists.

### VALUE-ADDED BENEFITS

#### HEARING DISCOUNT PROGRAM

[amplifonusa.com/dn](https://amplifonusa.com/dn)

Access to discounts on hearing aids and services.<sup>5</sup>

#### DIGIBITE TELEDENTISTRY APP

[DominionNational.com/teledentistry](https://DominionNational.com/teledentistry)  
Receive a dental consultation without leaving your home or office!

#### Z DENTAL DISCOUNT

[Myzsonic.com/DN](https://Myzsonic.com/DN)

Access exclusive discounts on premium oral care products and accessories offered by Z Dental.

<sup>1</sup> Dominion National Internal Performance Report, 2022.

<sup>2</sup> Networks and products vary by state. Check availability on your state marketplace.

<sup>3</sup> Participating providers are subject to change.

<sup>4</sup> 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.

<sup>5</sup> Visit [amplifonusa.com/dn](https://amplifonusa.com/dn) for full details. Hearing services are administered by Amplifon Hearing Health Care Corp.

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



## Elite PPO Premium (PA) Coverage Schedule, Limitations and Exclusions for Adult Services (age 19 and over)

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	90%	None
2	Basic Services	80%	6 months	70%	6 months
3	Major Services	50%	12 months	40%	12 months
4	Orthodontic Services	0%	N/A	0%	N/A
Annual Deductible		In-Network		Out-of-Network	
Single Adult		\$50		\$50	
Three or More Adults		\$150		\$150	
Applies To		Class 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. 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.</li></ul>					
Maximums		In-Network		Out-of-Network	
Annual		\$1,500		\$1,500	
Lifetime Orthodontic		N/A		N/A	
<ul style="list-style-type: none"><li>The maximum listed is the dollar amount that the plan will pay towards the cost of dental care within the specified period per member.</li><li>The annual maximum is combined for in-network and out-of-network services.</li><li>The annual maximum applies to: Class 1, Class 2 and Class 3.</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.					

- Waiting period credit will be given for the length of time Member was covered under each benefit classification under the current employer's prior dental plan.
- If course of treatment is to exceed \$300, prior review is recommended.



Plan will pay either the Participating Dentist's negotiated fee or the Maximum Allowable Charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar Year including a maximum of one comprehensive evaluation per 36 months	100%	None	No	90%	None	No
1	Emergency or problem focused exam (D0140)	One per Calendar Year	100%	None	No	90%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	100%	None	No	90%	None	No
1	Biteewing x-rays	Two per Calendar Year	100%	None	No	90%	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	90%	None	No
1	Periapical x-rays		100%	None	No	90%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	90%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	90%	None	No
2	Simple extraction of teeth		80%	6 months	Yes	70%	6 months	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	80%	6 months	Yes	70%	6 months	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	6 months	Yes	70%	6 months	Yes
2	Antibiotic injections administered by a dentist		80%	6 months	Yes	70%	6 months	Yes
3	Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of pericoronal 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		50%	12 months	Yes	40%	12 months	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: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	50%	12 months	Yes	40%	12 months	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	50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One per lifetime	50%	12 months	Yes	40%	12 months	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	50%	12 months	Yes	40%	12 months	Yes
3	Study model	One per 36 months	50%	12 months	Yes	40%	12 months	Yes
3	Crown build-up for non-vital teeth		50%	12 months	Yes	40%	12 months	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	50%	12 months	Yes	40%	12 months	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	Repair of dentures or fixed bridgework	One per 24 months	50%	12 months	Yes	40%	12 months	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	50%	12 months	Yes	40%	12 months	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	12 months	Yes	40%	12 months	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	50%	12 months	Yes	40%	12 months	Yes
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	50%	12 months	Yes	40%	12 months	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	50%	12 months	Yes	40%	12 months	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	50%	12 months	Yes	40%	12 months	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		50%	12 months	Yes	40%	12 months	Yes
3	Prosthetic services, limited to: replacement of removable dentures or fixed bridges	That cannot be repaired after 7 years from the date of last placement	50%	12 months	Yes	40%	12 months	Yes
3	Prosthetic services, limited to: addition of teeth to existing partial denture		50%	12 months	Yes	40%	12 months	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)	50%	12 months	Yes	40%	12 months	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

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

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



## 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		\$400		N/A	
Two or More Children		\$800		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	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; protective 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	One (1) 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, per two (2) years.	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.