**Elite PPO Premium (VA)**

**Coverage Schedule for Adult Services**

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

<table>
<thead>
<tr>
<th>Benefit Coverage</th>
<th>In-Network</th>
<th>Out-of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Class II</td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>Class III</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Class IV</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Endo/Perio</td>
<td>Class III Benefits</td>
<td>Class III Benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Adult</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Three or More Adults</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Applies to all Benefits</td>
<td>No, Waived on Class I</td>
<td>No, Waived on Class I</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximums</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

* Annual Maximum applies to Class I, Class II and Class III Benefits.

<table>
<thead>
<tr>
<th>Out-of-Network Allowance</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
<td>MAC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waiting Periods</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>Class II</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Class III</td>
<td>12 months</td>
<td>12 months</td>
</tr>
<tr>
<td>Class IV</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- Deductible is combined for all services for each Calendar year per adult Member – maximum $150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.
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.

Class I. Diagnostic and Preventive Services:
1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:
1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist

Class III. Major Services:
1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveoectomy, alveoplasty, and frenectomy
   d. Excision of pericoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Tooth reimplantation and/or stabilization; tooth transplantation
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
d. Gingivectomy
e. Osseous surgery including flap entry and closure
f. One pedicle or free soft tissue graft per site per lifetime
g. One appliance (night guards) per 5 years (within 6 months of osseous surgery)
h. One full mouth debridement per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months

Class IV. Orthodontia Services: Not Covered
Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:
1. Services which are covered under worker’s compensation, employer’s liability laws or the Pennsylvania Motor Vehicle Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient’s dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
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.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member’s condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member’s continuous coverage under the plan.

Plan Exclusions:
1. Services which are covered under worker’s compensation, employer’s liability laws or the Pennsylvania Motor Vehicle Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient’s dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
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.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member’s condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member’s continuous coverage under the plan.
# Elite PPO Premium *Kids* (VA) Coverage Schedule for Pediatric Services

- under age 19 (coverage continues through end of month in which the Member turns 19) -

### Benefit Coverage

<table>
<thead>
<tr>
<th>Benefit Coverage</th>
<th>In-Network</th>
<th>Out-of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Class II</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Class III</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Class IV</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Endo/Perio</td>
<td>Class II Benefits</td>
<td>Class II Benefits</td>
</tr>
</tbody>
</table>

### Annual Deductible

<table>
<thead>
<tr>
<th>Applied to</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Child</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Two or More Children</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Applies to all Benefits</td>
<td>No, Waived on Class I and IV Benefits</td>
<td>No, Waived on Class I Benefits</td>
</tr>
</tbody>
</table>

### Out-of-Pocket Maximums

<table>
<thead>
<tr>
<th>Applied to</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Child</td>
<td>$350</td>
<td>N/A</td>
</tr>
<tr>
<td>Two or More Children</td>
<td>$700</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Annual Out-of-Pocket Maximum applies to all covered services for medically necessary treatment.*

### Out-of-Network Allowance

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>MAC</td>
</tr>
</tbody>
</table>

### Waiting Periods: None

- Deductible is combined for all covered services for each calendar year per pediatric Member – maximum $100 for pediatric Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, pre-authorization is required.
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.
Class I. Diagnostic and Preventive Services:
1. One (1) evaluation (D0120, D0145 or D0150) per six (6) months, per patient
2. One (1) re-evaluation limited or problem focused exam per six (6) months, per patient
3. One (1) prophylaxis (D1110 or D1120) per six (6) months, per patient
4. One (1) fluoride treatment is covered per six (6) months, per patient
5. Bitewing x-rays
6. Periapical x-rays (not on the same date of service as a panoramic radiograph)
7. Full mouth or panoramic x-rays
8. One (1) space maintainer per 24 months, per quadrant (unilateral) or per arch (bilaterial), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recreation of space maintainer; removal of fixed space maintainer (cannot be billed by the provider or practice that placed the appliance)
9. One (1) sealant per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)
10. Diagnostic cast only if not in conjunction with orthodontic treatment

Class II. Basic Services:
1. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 12 months
2. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
3. Local anesthesia; general anesthesia and analgesic, including intravenous and non-intravenous sedation with a maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure codes D9223 or D9243); intravenous conscious sedation is not covered with procedure codes D9223 or D9230; non-intravenous conscious sedation is not covered with procedure codes D9223 or D9230; analgesia (nitrous oxide) is not covered with procedure codes D9223 or D9243; requires a narrative of medical necessity be maintained in patient records
4. 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 service can be rendered
5. Occlusal guard, by report (for grinding and clenching of teeth)
6. Therapeutic parenteral drug administration (note medication on claim), desensitizing medicaments
7. Consultations when not performed by another dentist within the same facility and not in conjunction with orthodontia
8. Prefabricated crowns, one per tooth, per 36 months
9. Temporary crowns for a fractured tooth
10. Pin retention of fillings (multiple pins on the same tooth are allowable as one (1) pin)
12. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally.
13. Recement cast or prefabricated post and core; recement crown
14. Protective restoration
15. Labial veneer per 60 months, one (1) per tooth (will be considered as an alternative to a full restoration for an endodontically treated tooth)
16. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root or partial tooth
   c. Alveoplasty, frenectomy and frenuloplasty
   d. Excision of pericoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy
e. Tooth reimplantation and/or stabilization; tooth transplantation
f. Excision of a lesion, tumor or cyst and incision and drainage of an abscess or cyst
g. Removal of oral tissue, odontogenic cyst, torus palatinus and mandibularis (D7285, D7286)
h. Oroantral fistula closure and primary closure of a sinus perforation
i. Biopsy
j. Occlusal orthotic device for TMJ (D7880)
17. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
   a. Root canal therapy, once per permanent tooth, per lifetime, per patient; retreatment of previous root canal therapy, once per lifetime, not within 24 months when done by same dentist or dental office
   b. Pulpotomy and pulp cap
   c. Pulpal therapy and pulpal debridement
   d. Pulpal regeneration
   e. Apexification/recalcification (D3351, D3352) limited to three (3) treatments; D3353 limited to one (1) per tooth, per patient, per lifetime
   f. Periapical surgery without apicoectomy, one per tooth, per lifetime
   g. Apicoectomy, one (1) per tooth, per patient, per lifetime
18. Periodontic services, limited to:
   a. Four (4) periodontal cleanings following surgery (D4341 is not considered surgery) per 12 months after definitive periodontal therapy
   b. One (1) root scaling and planing per 24 months, per quadrant, per patient
c. Occlusal adjustment performed with covered surgery
d. Gingivectomy or gingivoplasty, once per 24 months, per quadrant, per patient
e. Osseous surgery including flap entry and closure, once per 24 months, per quadrant, per patient
f. Provisional splinting
g. Pedece, subepithelial, bone replacement or free soft tissue graft
h. One (1) full mouth debridement per 12 months, only covered when there is substantial gingival inflammation in all four (4) quadrants

Class III. Major Services:
1. Restoration services, limited to:
   a. Initial placement of dentures
   b. Repair of dentures; rebonding or recementing fixed denture
c. Denture adjustment
d. Replacement of dentures that cannot be repaired after five (5) years from the date of last placement
   e. Addition of teeth or clasp to existing partial denture
   f. One (1) relining or rebasing of existing removable dentures per 24 months (only after six (6) months from date of last placement)
g. Feeding aid (D9591)
h. Construction and repair of bridges (replacement of a bridge that cannot be repaired limited to once in 60 months)
i. Tissue conditioning
j. Recement fixed partials as needed

Class IV. “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 are only provided for severe, dysfunctional, handicapping malocclusion.

Plan Exclusions:
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.
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 implant, 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, 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 covered. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient’s responsibility.