The dental plan is underwritten by HPHC Insurance Company, Inc. d/b/a Point32Health Dental.

Point32Health Dental

Point32Health Dental PPO Choice
Coverage Schedule, Limitations and Exclusions

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	100%	None
2	Basic Services	90%	None	90%	None
3	Major Services	60%	None	60%	None
4	Orthodontic Services	0%	None	0%	None

Annual Deductible	In-Network	Out-of-Network
Amount	$50	$50
Maximum Per Family	$150	$150
Applies To	Class 2, Class 3	Class 2, Class 3

• Each member must pay the deductible amount for dental services before the plan will begin to cover the member's dental procedures. The deductible is combined for all applicable services for each Benefit year per member.

Maximums	In-Network	Out-of-Network
Annual	$1,500	$1,500
Lifetime Orthodontic	Not Covered	Not Covered

• 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 2, Class 3

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	90th

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Point32Health Dental or Point32Health Dental leased dental networks. As such, OON providers set their own fees and Point32Health 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 Point32Health's Dental INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

Rollover Services	Service Maximum (Paid by Plan)	Rollover Maximum
Maximum Amounts	$750	$1,875

- A member may be eligible for a rollover of unused annual maximum for Class 1, Class 2 and Class 3 Services. The following requirements must be adhered to:
  - At least one claim must be submitted for Class 1 covered services during the Benefit year.
  - The member must have received services in excess of any deductible.
  - The member must not have received services that exceed the service maximum, which is the amount paid by the plan.
  - If eligible, the amount of rollover services may not be greater than the rollover maximum.
  - A member's rollover services may be eliminated, and the accrued service lost, if there is a break in coverage of any length of time, for any reason, or if the service maximum is exceeded in any given Benefit year.

- If course of treatment is to exceed $300, prior review is recommended.

HPHC Insurance Company, Inc.; 1 Wellness Way, Canton, MA 02021-1166
1.866.615.4963; www.point32health.org/dental-login

NH Form No. 2941
MA Form No. 2935
ME Form No. 2947
RI Form No. 2953

CD0000500034

Plan will pay either the participating dentist's negotiated fee or the 90th percentile usual and customary fees (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	100%	None	No	100%	None	No
1	Emergency or problem focused exam (D0140)	One per Calendar Year	100%	None	No	100%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year ; one additional cleaning is covered for expecting mothers or diabetics	100%	None	No	100%	None	No
1	Topical fluoride	One per Calendar Year, to age 19	100%	None	No	100%	None	No
1	Bitewing x-rays	Two per Calendar Year	100%	None	No	100%	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	100%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	100%	None	No
1	Sealants	One per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)	100%	None	No	100%	None	No
1	Periapical x-rays		100%	None	No	100%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	100%	None	No
2	Simple extraction of teeth		90%	None	Yes	90%	None	Yes
2	Amalgam and composite fillings	Excluding pre-molar and molar composite fillings Per tooth, per surface every 24 months Pre-molar and molar composite fillings will be given an alternate benefit of an amalgam filling	90%	None	Yes	90%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	90%	None	Yes	90%	None	Yes
2	Antibiotic injections administered by a dentist		90%	None	Yes	90%	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	Space maintainers	Used to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)	90%	None	Yes	90%	None	Yes
2	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 tabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst		90%	None	Yes	90%	None	Yes
2	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	90%	None	Yes	90%	None	Yes
2	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	90%	None	Yes	90%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy and apicoectomy		90%	None	Yes	90%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	90%	None	Yes	90%	None	Yes
2	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	90%	None	Yes	90%	None	Yes
2	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	90%	None	Yes	90%	None	Yes
2	Periodontic services, limited to: occlusal adjustment performed with covered surgery, gingivectomy, osseous surgery including flap entry and closure		90%	None	Yes	90%	None	Yes
2	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	90%	None	Yes	90%	None	Yes

2	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	90%	None	Yes	90%	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	90%	None	Yes	90%	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 prophylaxis (D1110/D1120), limited to one per two years	90%	None	Yes	90%	None	Yes
3	Study model	One per 36 months	60%	None	Yes	60%	None	Yes
3	Crown build-up for non-vital teeth		60%	None	Yes	60%	None	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	60%	None	Yes	60%	None	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	60%	None	Yes	60%	None	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery, or implant placement procedures	60%	None	Yes	60%	None	Yes
3	Infiltration of sustained release therapeutic drug - single or multiple sites		60%	None	Yes	60%	None	Yes
3	Restoration services, limited to: cast metal, resin-based 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	60%	None	Yes	60%	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	60%	None	Yes	60%	None	Yes
3	Restoration services, limited to: stainless steel crowns	Up to age 14 (one per primary tooth per lifetime)	60%	None	Yes	60%	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	60%	None	Yes	60%	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 2 years	60%	None	Yes	60%	None	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		60%	None	Yes	60%	None	Yes

3	Prosthetic services, limited to: replacement of removable dentures or fixed bridges	That cannot be repaired after 7 years from the date of last placement	60%	None	Yes	60%	None	Yes
3	Prosthetic services, limited to: addition of teeth to existing partial denture		60%	None	Yes	60%	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)	60%	None	Yes	60%	None	Yes
3	Prosthetic services, limited to: tissue conditioning	One treatment per 7 years (not covered when performed within 6 months of any denture)	60%	None	Yes	60%	None	Yes
3	Implants and related services	Once per tooth per 60 months, age 16 or older	60%	None	Yes	60%	None	Yes

Plan Exclusions

1. Services which are covered under worker's compensation or employer's liability laws. This applies even if the member has filed an exemption from worker's compensation requirements or is exempt from worker's compensation laws.
2. Services which are not necessary for the patient's dental health as determined by the plan.
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 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 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 nonpathologic, asymptomatic impacted teeth including third molars.
12. Procedures not listed as covered services under this plan.
13. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; 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.

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Your plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Your plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Your plan provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call **866-615-4963** (TTY: 711).

If you believe that your plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator. You can file a grievance by mail, fax, or email at:

Dominion National
P.O. Box 211424, Eagan, MN 55121
888-518-5338 (TTY: 711), fax: 703-518-4450
CRC@DominionNational.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building Washington, D.C. 20201
Toll-free: 800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

For no cost translation, call 866-615-4963 (TTY: 711).

Arabic للتمتع بترجمة مجانية إلى اللغة العربية، الرجاء االتصال بالرقم 866-615-4963)بالنسبة لمستخدمي الهواتف النصية: 711(.

Chinese 如需免費的繁體中文翻譯服務，請致電866-615-4963（聽障電話：711).

French Pour une traduction gratuite en français, appeler le 866-615-4963 (TTY : 711).

German Benötigen Sie eine deutsche Übersetzung, rufen Sie bitte die 866-615-4963 (TTY: 711).
Die Übersetzung ist für Sie kostenlos.

Greek Για δωρεάν μετάφραση στα ελληνικά, τηλεφωνήστε στο 866-615-4963 (TTY: 711).

Gujarati વિના મૂલ્ય ભાષાંતર માટે, કૉલ કરો 866-615-4963 ટીટીવાય: 711)

Haitian Creole Pou w ka jwenn tradiksyon gratis an Kreyòl Ayisyen, rele 866-615-4963 (TTY: 711).

Hindi भाषा में निःशुल्क अनुवाद के लिए, 866-615-4963 पर कॉल करें। (TTY: 711).

Italian Per servizi di traduzione gratuiti in Italiano, chiamare il 866-615-4963 (TTY: 711).

Japanese 日本語への無料翻訳をご希望の場合は、866-615-4963 までお電話ください (TTY: 711)

Khmer ដើម្បីទទួលបានការបកប្រែដោយឥតគិតថ្លៃជាភាសាខ្មែរ សូមទូរសព្ទទៅ 866-615-4963។ (TTY: 711)។

Korean 무료 한국어 번역을 원하시면 866-615-4963 (TTY: 711) 번으로 전화하십시오.

Laotian ສໍາລັ ບການບໍ່ ເສຍຄ່ າໃນການແປພາສາລາວ, ກະລຸ ນາໂທ 866-615-4963 (TTY: 711).

Navajo T’áá ch’íík’eh shá atxa’ hodoonih nínízingo, kojį’ hodíílnih 866-615-4963 (TTY: 711).

Persian .(TTY: 711) تماس بگیرید 866-615-4963 برای ترجمه بدون هزینه در فارسی، با

Polish Tłumaczenie bezpłatne w Polski, Tel. 866-615-4963 (TTY: 711).

Portuguese Para uma tradução gratuita para português, contacte o número 866-615-4963 (TTY: 711).

Russian За бесплатным переводом на русский язык обращайтесь по номеру телефона 866-615-4963 (TTY: 711).

Spanish Para traducción sin costo en español, llame al 866-615-4963 (TTY: 711).

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tumawag sa 866-615-4963 (TTY: 711).

Vietnamese Về dịch vụ phiên dịch tiếng Việt miễn phí, hãy gọi 866-615-4963 (TTY: 711).