## Individual Select Dental HMO
### Selected Benefits At-a-Glance

<table>
<thead>
<tr>
<th>Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Dental Services (Per Office Visit Copay)</strong></td>
<td></td>
</tr>
<tr>
<td>Includes all examinations, prophylaxis, X-rays, oral hygiene instruction, sealants, pulp caps, amalgam and composite restorations, sedative fillings, simple extractions, recementation of space maintainers, inlay(s), crown(s) or bridge, pin retention, complete or partial denture adjustments, palliative treatment and follow-up visits for major procedures.</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Soft Tissue Management (Per Office Visit Copay)</strong></td>
<td>$70</td>
</tr>
<tr>
<td>Includes all periodontal scaling and root planing, full mouth debridement, periodontal maintenance procedures following active therapy.</td>
<td></td>
</tr>
<tr>
<td><strong>Restorative Services</strong></td>
<td></td>
</tr>
<tr>
<td>Crown – porcelain fused to predominantly base metal</td>
<td>$415</td>
</tr>
<tr>
<td>Crown – porcelain fused to high noble metal</td>
<td>$460</td>
</tr>
<tr>
<td><strong>Endodontics – Root Canal Therapy</strong></td>
<td>$300/$400*</td>
</tr>
<tr>
<td>Anterior (excluding final restoration)</td>
<td></td>
</tr>
<tr>
<td>Molar (excluding final restoration)</td>
<td>$450/$600*</td>
</tr>
<tr>
<td><strong>Dentures and Related Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>Complete denture – maxillary or mandibular</td>
<td>$495</td>
</tr>
<tr>
<td>Partial denture – cast metal framework with resin denture bases</td>
<td>$550</td>
</tr>
<tr>
<td>Reline complete maxillary or mandibular denture (in a dentist’s office)</td>
<td>$120</td>
</tr>
<tr>
<td>Pontic – porcelain fused to predominantly base metal</td>
<td>$415</td>
</tr>
<tr>
<td>Pontic – porcelain fused to high noble metal</td>
<td>$460</td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td></td>
</tr>
<tr>
<td>Osseous Surgery (including flap entry and closure) per quadrant</td>
<td>$420/$600*</td>
</tr>
<tr>
<td>Surgical removal of erupted tooth</td>
<td>$80/$110*</td>
</tr>
<tr>
<td>Removal of impacted tooth – completely bony</td>
<td>$165/$200*</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td></td>
</tr>
<tr>
<td>Comprehensive – adolescent</td>
<td>$2,500</td>
</tr>
<tr>
<td>Comprehensive – adult</td>
<td>$2,700</td>
</tr>
<tr>
<td>Pre-orthodontic treatment visit</td>
<td>$150</td>
</tr>
<tr>
<td>Orthodontic retention</td>
<td>$250</td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td></td>
</tr>
<tr>
<td>Intravenous sedation (first 30 minutes)</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Broken Appointment Fee</strong></td>
<td>$10</td>
</tr>
<tr>
<td>Per 15 minutes (without 24 hour notice)</td>
<td></td>
</tr>
</tbody>
</table>

* When two copays are listed, the primary dentist will provide the service at the lower amount, and the specialty care dentist will provide the service at the higher amount.

This chart includes common procedures and does not list all services and procedures covered by your benefits contract. It is for comparison purposes only and does not create rights that are not covered through the benefit plan.
Exclusions and Limitations

MARYLAND

PLAN LIMITATIONS. The following exclusions and limitations shall apply:

- Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws;
- Services which are provided without cost to the Covered Individual and/or Dependent(s) by any municipality, county or other political subdivision (with the exception of Medicaid);
- Services which, in the opinion of the Participating DENTIST, are not necessary for the Covered Individual and/or Dependent(s) health;
- Payment of any claim or bill will not be made for prohibited referrals;
- Cosmetic, elective, or aesthetic dentistry, which in the opinion of the Participating DENTIST are not necessary for the patient's dental health;
- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
- Dispensing of drugs, except those used as a local anesthetic;
- Hospitalization for any dental procedure;
- Loss or theft of bridgework or dentures previously supplied under the PLAN;
- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
- Any implantation;
- General anesthesia;
- Services that cannot be performed because of the general health of the patient;
- Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;
- Unlisted procedures will be provided at the dentist's charge;
- Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
- Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual and/or Dependent(s) Personal Participating DENTIST; all services listed on the Schedule of Benefits and Copayments will be provided by a general Participating DENTIST or an Approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an Approved Specialist or recommend that the Covered Individual or Dependent contact an Approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an Approved Specialist, with an exception for out-of-area emergency care, and a referral to a non-participating general dentist or specialist;
- Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

OUT-OF-AREA EMERGENCY CARE: Covered Individuals and/or Dependents are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than fifty (50) miles from their "Personal Participating DENTIST." Limited to $50 per Covered Individual or Dependent per emergency, minus member's copay.

DISTRICT OF COLUMBIA

PLAN LIMITATIONS. The following in-network exclusions and limitations shall apply:

A. Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws;
B. Services which are provided without cost to the Covered Individual by any municipality, county or other political subdivision (with the exception of Medicaid);
C. Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Individual's health;
D. Payment of any claim or bill will not be made for prohibited referrals;
E. Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient's dental health;
F. Oral surgery requiring the setting of fractures or dislocations;
G. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
H. Dispensing of drugs, except those used as a local anesthetic;
I. Hospitalization for any dental procedure;
J. Loss or theft of bridgework or dentures previously supplied under the PLAN;
K. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
L. Any implantation;
M. General anesthesia;
O. Services that cannot be performed because of the general health of the patient;
P. Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;
Exclusions and Limitations

Q. Unlisted procedures will be provided at the dentist’s charge;
R. Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
S. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual’s General Participating DENTIST.
T. All services listed on the Schedule of Benefits and Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care.
U. Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

OUT-OF-AREA EMERGENCY CARE: Members are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest PLAN Dental Office. Limited to $50 per member per emergency, minus member’s copay.

VIRGINIA

PLAN LIMITATIONS. The following limitations shall apply:
A. All services listed on the Schedule of Benefits and Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care;
B. Unlisted procedures will be provided at the dentist’s charges;
C. Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual’s General Participating DENTIST;
D. OUT-OF-AREA EMERGENCY CARE: Members are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest PLAN Dental Office. Limited to $50 per member per emergency, minus member’s copay.

EXCLUSIONS. Benefits will not be provided for:
A. Services for injuries and conditions which are covered under Workers’ Compensation or Employers’ Liability Laws;
B. Services which are provided without cost to the Covered Individual by any municipality, county or other political subdivision (with the exception of Medicaid);
C. Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Individual’s health;
D. Oral surgery requiring the setting of fractures or dislocations;
E. Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
F. Dispensing of drugs, except those used as a local anesthetic;
G. Hospitalization for any dental procedure;
H. Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
I. Any implantation;
J. General anesthesia;
K. Teeth Cleaning (Prophylaxis) limited to twice per Coverage Period;
L. Services which are obtained outside the dental office in which enrolled and which are not preauthorized by the PLAN. This does not apply to out-of-area emergency dental services;
M. Services which cannot be performed in the dental office of the “Personal Participating DENTIST” or “Approved Specialist” due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).
N. All Member Copayments listed on the Schedule of Benefits and Copayments are exclusive of gold;
O. Payment of any claim or bill will not be made for prohibited referrals.

MD GHMSI
MD GHMSI/DB/ISPP IEA (10/11), MD GHMSI/DB/ISPP DOCS (10/11), MD/GHMSI/ISPP/AMEND (2/12), MD/GHMSI/DB/DENT/ES (10/11)

MD CFMI
CFMI/DB/ISPP IEA (10/11) and CFMI/DB/ISPP DOCS (10/11), MD/CFMI/ISPP/AMEND (2/12), MD/CFMI/DB/DENT/ES (2/12)

VA
VA/GHMSI/ISPP IEA (10/11), VA/GHMSI/ISPP/DOCS (10/11), VA/GHMSI/ISPP/AMEND (2/12), VA/GHMSI/DB/ES (10/11)

DC
DC/GHMSI/DB/ISPP IEA (10/11), DC/GHMSI/ISPP/DOCS (10/11), DC/GHMSI/ISPP/AMEND (2/12)