DOMINION® NATIONAL

A Better Path to Benefits

A COMPANY AS *unique* AS YOU

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 OVER 900,000 MEMBERS,[1] DELIVERING:

EXTENSIVE NETWORKS[2]

Choice PPO network offers access to over 325,000 dentists nationally.[1,3]

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.[3,5]

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

A COMMITMENT TO MEMBER SATISFACTION

In a recent Member Satisfaction Survey, 97% of the respondents were satisfied with Dominion as their dental plan.[4]

TOLL-FREE, 24 HOUR ACCESS at 888.518.5338

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

SECURE ONLINE ACCESS TO YOUR ACCOUNT

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

MEMBER PORTAL
DominionMembers.com

GO MOBILE COMMUNICATION SERVICE
Register by calling 888.596.0716 or texting "DN GO" to 73529

MyDOMINION MOBILE APP
Download at DominionNational.com/mobile

1 Dominion National Internal Performance Report, 2018.
2 Networks vary by state. Check availability on your state marketplace.
3 Participating providers are subject to change.
4 Dominion National Member Satisfaction Survey, November 2018.
5 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, 2018. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.

251 18th Street South, Suite 900 Arlington, VA 22202

DN(IC).SB.HCR.080119

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National (hereinafter referred to as "Dominion").

DOMINION® NATIONAL DENTAL

Elite ePPO Basic (MD)
Description of Services, Member Copayments, Exclusions and Limitations for Adult Services (age 19 and over)

- Coverage begins the first day of the month following the month in which the Member turns 19 -

Plan Highlights

- This plan has fixed copayments. In-network (INN) providers have contracted with Dominion and accept the INN member copayment as payment in full.
- There is no out-of-network coverage (with the exception of out-of-area emergency services and/or for services provided when a Member is referred to an out-of-network specialist).
- There are no waiting periods.
- If course of treatment is to exceed $300, prior review is recommended.

Annual Deductible	In-Network
Single adult	$25
Three or more adults	$75
Applies to:	Class 2 and Class 3

- Each member must pay the in-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $25 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 $75 per calendar year at which point the deductible is waived for remaining adult Members.

Maximums	In-Network
Annual	$1,500
Lifetime Ortho	N/A
The annual maximum applies to: Class 1, Class 2 and Class 3	

- The maximum listed is the dollar amount that the plan will pay toward the cost of dental care within the specified period per member.

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, 2 and 3 Services. The following requirements must be adhered to.
  - At least one claim must be submitted for Class 1 covered services during the calendar 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 calendar year.

ADA CODE	DESCRIPTION	IN
Class 1 - Diagnostic/Preventive		
D0120	Periodic oral eval - established patient	0
D0140	Limited oral eval - problem focused	0
D0150	Comprehensive oral eval - new or established patient	0
D0160	Detailed and extensive oral eval - problem focused	0
D0170	Re-evaluation - limited, problem focused	0
D0180	Comp. periodontal eval - new or established patient	0
D0210	Intraoral - complete series of radiographic images	0
D0220	Intraoral - periapical first radiographic image	0
D0230	Intraoral - periapical each add. radiographic image	0
D0240	Intraoral - occlusal radiographic image	0
D0250	Extraoral - 2D projection radiographic image	0
D0270	Bitewing x-rays - single radiographic image	0
D0272	Bitewing x-rays - two radiographic images	0
D0273	Bitewing x-rays - three radiographic image	0
D0274	Bitewing x-rays - four radiographic images	0
D0277	Vertical bitewings - 7 to 8 radiographic images	0
D0330	Panoramic radiographic image	0
D0340	2D cephalometric radiographic image	0
D0350	2D oral/facial photographic images	0
D0460	Pulp vitality tests	0

ADA CODE	DESCRIPTION	IN
D0999	Chlorhexidine mouth rinse or fluoride toothpaste (twice per year for 2 years; covered only following scaling and root planing (a deep cleaning) and must be dispended in the dentist's office)	0
D1110	Prophylaxis (cleaning) - adult	0
Class 2 - Restorative (Fillings)		
D2140	Amalgam - one surface, prim. or perm.	20
D2150	Amalgam - two surfaces, prim. or perm.	30
D2160	Amalgam - three surfaces, prim. or perm.	40
D2161	Amalgam - >=4 surfaces, prim. or perm.	55
D2330	Resin-based composite - one surface, anterior	32
D2331	Resin-based composite - two surfaces, anterior	42
D2332	Resin-based composite - three surfaces, anterior	52
D2335	Resin-based composite - >=4 surfaces, anterior	100
D2390	Resin-based composite crown, anterior	70
D2391	Resin-based composite - one surface, posterior	45
D2392	Resin-based composite - two surfaces, posterior	55
D2393	Resin-based composite - three surfaces, posterior	65
D2394	Resin-based composite - >=4 surfaces, posterior	115
Class 3 - Crown & Bridge		
D2510	Inlay - metallic - one surface	261
D2520	Inlay - metallic - two surfaces	336
D2530	Inlay - metallic - three or more surfaces	375
D2542	Onlay - metallic - two surfaces	355
D2543	Onlay - metallic - three surfaces	375
D2544	Onlay - metallic - four or more surfaces	391
D2610	Inlay - porcelain/ceramic - one surface	317
D2620	Inlay - porcelain/ceramic - two surfaces	331
D2630	Inlay - porcelain/ceramic - >=3 surfaces	374
D2642	Onlay - porcelain/ceramic - two surfaces	375
D2643	Onlay - porcelain/ceramic - three surfaces	391
D2644	Onlay - porcelain/ceramic - >=4 surfaces	393
D2650	Inlay - resin-based composite - one surface	317
D2651	Inlay - resin-based composite - two surfaces	331
D2652	Inlay - resin-based composite - >=3 surfaces	374
D2662	Onlay - resin-based composite - two surfaces	375
D2663	Onlay - resin-based composite - three surfaces	391
D2664	Onlay - resin-based composite - >=4 surfaces	393
D2710	Crown - resin based composite (indirect)	433
D2712	Crown - 3/4 resin-based composite (indirect)	433
D2720	Crown - resin with high noble metal	465
D2721	Crown - resin with predominately base metal	450
D2722	Crown - resin with noble metal	450
D2740	Crown - porcelain/ceramic	545
D2750	Crown - porcelain fused to high noble metal	570
D2751	Crown - porcelain fused to predominately base metal	520
D2752	Crown - porcelain fused to noble metal	520
D2780	Crown - 3/4 cast high noble metal	393
D2781	Crown - 3/4 cast predominately base metal	368
D2782	Crown - 3/4 cast noble metal	391
D2783	Crown - 3/4 porcelain/ceramic	400
D2790	Crown - full cast high noble metal	507
D2791	Crown - full cast predominately base metal	455
D2792	Crown - full cast noble metal	473
D2794	Crown - titanium	530
D2910	Recement inlay, onlay/crown or partial coverage rest.	34
D2915	Recement cast of prefabricated post and core (once in a lifetime)	34
D2920	Recement inlay, onlay/crown or partial coverage rest.	27
D2930	Prefab. stainless steel crown - prim. tooth	90
D2931	Prefab. stainless steel crown - perm. tooth	90
D2932	Prefabricated resin crown	66
D2933	Prefabricated stainless steel crown with resin window (once every 24 months on anterior primary tooth)	84
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth (once every 24 months on anterior primary tooth)	84
D2940	Protective restoration	30
D2950	Core buildup, including any pins	100
D2951	Pin retention - per tooth, in addition to restoration	28
D2952	Post and core in addition to crown	141
D2953	Each additional indirectly fabricated post, same tooth, indirectly fabricated	77
D2954	Prefab. post and core in addition to crown	105
D2961	Labial veneer (resin laminated) - laboratory (not covered if considered cosmetic; once per 60 months)	285
D2962	Labial veneer (porcelain laminated) - laboratory (not covered if considered cosmetic; once per 60 months)	436
D2971	Additional procedures to construct new crown under existing partial denture framework (once per tooth per 60 months)	54
D2980	Crown repair necessitated by restorative material failure	85
D2981	Inlay repair necessitated by restorative material failure	85
D2982	Onlay repair necessitated by restorative material failure	85
Class 3 - Endodontics		
D3110	Pulp cap - direct (excl. final restoration)	13
D3120	Pulp cap - indirect (excl. final restoration)	13
D3220	Therapeutic pulpotomy (excl. final restor.)	100
D3221	Pulpal debridement, prim. and perm. teeth	100
D3222	Partial pulpotomy for apexogenesis (once per permanent tooth per lifetime for patients under 19 years)	100
D3230	Pulpal therapy (resorbable filling) anterior primary tooth (excluding final restoration and on primary molar without a permanent successor)	90
D3240	Pulpal therapy (resorbable filling) posterior primary tooth (excluding final restoration and on primary molar without a permanent successor)	102

ADA CODE	DESCRIPTION	IN
D3310	Endodontic therapy, anterior tooth (excl. final restor.)	550
D3320	Endodontic therapy, premolar tooth (excl. final restor.)	640
D3330	Endodontic therapy, molar tooth (excl. final restor.)	780
D3331	Treatment of root canal obstruction; non-surgical access	127
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	234
D3333	Internal root repair of perforation defects	119
D3346	Retreat of prev. root canal therapy - anterior	569
D3347	Retreat of prev root canal therapy - premolar	658
D3348	Retreat of prev. root canal therapy - molar	776
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) for permanent teeth and must follow 4-6 months of healing or narrowing of canal	170
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) for permanent teeth and must follow 4-6 months of healing or narrowing of canal)	83
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	179
D3410	Apicoectomy - anterior	414
D3421	Apicoectomy - premolar (first root)	446
D3425	Apicoectomy - molar (first root)	543
D3426	Apicoectomy - (each add. root)	145
D3430	Retrograde filling - per root	138
D3450	Root amputation - per root	258
D3920	Hemisection, not inc. root canal therapy	194

Class 3 - Periodontics

D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	198
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	100
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	368
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	221
D4249	Clinical crown lengthening - hard tissue (covered when bone removed, once per tooth per 60 months)	379
D4260	Osseous surgery - >3 cont. teeth, per quad	600
D4261	Osseous surgery - <=3 cont. teeth, per quad	360
D4263	Bone replacement graft - retained natural tooth - first site in quadrant (once per site per 36 months)	230
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant, not to exceed 2 sites in a quadrant (once per site per 36 months)	134
D4265	Biological materials to aid in soft and osseous tissue regeneration (once per site per 36 months)	194
D4266	Guided tissue regeneration - resorbable barrier, per site (not to exceed 2 sites in a quadrant per 36 months)	341
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal; not to exceed 2 sites in a quadrant per 36 months)	358
D4270	Pedicle soft tissue graft procedure (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	401
D4273	Autogenous connective tissue graft procedures (including donor site surgery; once per tooth per 36 months, not to exceed 2 teeth per 36 months)	626
D4274	Mesial/distal wedge procedure, single tooth	194
D4275	Non-autogenous connective tissue graft (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	405
D4276	Combined connective tissue and double pedicle graft (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	544
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	381
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	30
D4341	Perio scaling and root planing - >3 cont teeth, per quad	97
D4342	Perio scaling and root planing - <= 3 teeth, per quad	52
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	30
D4355	Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	60
D4381	Localized delivery of antimicrobial agents	42
D4910	Periodontal maintenance	75
D4920	Unscheduled dressing change (by someone other than treating dentist)	49

Class 3 - Prosthetics (Dentures)

D5110	Complete denture - maxillary/mandibular	560
D5120	Complete denture - maxillary/mandibular	560
D5130	Immediate denture - maxillary/mandibular	565
D5140	Immediate denture - maxillary/mandibular	565
D5211	Maxillary/mandibular partial denture - resin base	375
D5212	Maxillary/mandibular partial denture - resin base	375
D5213	Maxillary/mandibular partial denture - cast metal	625
D5214	Maxillary/mandibular partial denture - cast metal	625
D5221	Immediate maxillary partial denture - resin base	375
D5222	Immediate mandibular partial denture - resin base	375

ADA CODE	DESCRIPTION	IN
D5223	Immediate maxillary partial denture - cast metal	625
D5224	Immediate mandibular partial denture - cast metal	625
D5225	Maxillary/mandibular partial denture - flexible base	625
D5226	Maxillary/mandibular partial denture - flexible base	625
D5282	Rem. unilateral partial denture - one piece cast metal, maxillary	318
D5283	Rem. unilateral partial denture - one piece cast metal, mandibular	318
D5410/11	Adjust complete denture - maxillary/mandibular	20
D5421/22	Adjust partial denture - maxillary/mandibular	20
D5511	Repair broken complete denture base, mandibular	59
D5512	Repair broken complete denture base, maxillary	59
D5520	Replace missing or broken teeth - complete denture	65
D5611	Repair resin partial denture base, mandibular	59
D5612	Repair resin partial denture base, maxillary	59
D5621	Repair cast partial framework, mandibular	59
D5622	Repair cast partial framework, maxillary	59
D5630	Clasp repaired, replaced or added	59
D5640	Replace broken teeth - per tooth	65
D5650	Add tooth to existing partial denture	65
D5660	Clasp repaired, replaced or added	70
D5670	Replace all teeth and acrylic on cast metal framework	245
D5671	Replace all teeth and acrylic on cast metal framework	245
D5710/11	Rebase complete maxillary/mandibular denture	185
D5720/21	Rebase maxillary/mandibular partial denture	110
D5730/31	Reline complete maxillary/mandibular denture (chairside)	93
D5740/41	Reline maxillary/mandibular partial denture (chairside)	93
D5750/51	Reline complete maxillary/mandibular denture (lab)	134
D5760/61	Reline maxillary/mandibular partial denture (lab)	134
D5820/21	Interim partial denture - maxillary/mandibular	228
D5850/51	Tissue conditioning - maxillary/mandibular	41
D5863	Overdenture – complete maxillary	600
D5864	Overdenture – partial maxillary	565
D5865	Overdenture – complete mandibular	600
D5866	Overdenture – partial mandibular	565

Class 3 - Implant Services

D6010	Surgical placement of implant body: endosteal implant (in lieu of 3 unit bridge; for age 16 and older; once per tooth per 60 months)	1360
D6056	Prefabricated abutment (includes placement)	468
D6057	Custom abutment (includes placement)	560
D6058	Abutment supported porcelain/ceramic crown	705
D6059	Abutment supported porcelain fused to metal crown (high noble)	665
D6060	Abutment supported porcelain fused to metal crown (base metal)	600
D6061	Abutment supported porcelain fused to metal crown (noble metal)	640
D6062	Abutment supported cast metal crown (high noble)	632
D6063	Abutment supported cast metal crown (base metal)	600
D6064	Abutment supported cast metal crown (noble metal)	620
D6065	Implant supported porcelain/ceramic crown	705
D6066	Implant supported porcelain fused to metal crown (titanium, titanium allowy, high noble metal)	665
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	665
D6081	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	52
D6090	Repair implant supported prosthesis, by report (once in 12 months per tooth)	76
D6092	Recement implant/abutment supported crown (once per tooth after 6 months from initial placement)	24
D6093	Recement implant/abutment supported fixed partial denture (once in 12 months after 6 months from initial placement)	35
D6094	Abutment supported crown (titanium)	640
D6095	Repair implant abutment, by report (once per year after 24 months of initial placement)	140
D6100	Implant removal, by report (once per tooth)	116

Class 3 - Bridge & Pontics

D6205	Pontic - indirect resin based composite	520
D6210	Pontic - cast high noble metal	510
D6211	Pontic - cast predominately base metal	463
D6212	Pontic - cast noble metal	473
D6214	Pontic - titanium	520
D6240	Pontic - porcelain fused to high noble metal	570
D6241	Pontic - porcelain fused to predominately base metal	520
D6242	Pontic - porcelain fused to noble metal	520
D6245	Pontic - porcelain/ceramic	500
D6250	Pontic - resin with high noble metal	552
D6251	Pontic - resin with predominately base metal	442
D6252	Pontic - resin with noble metal	508
D6545	Retainer - cast metal for resin bonded fixed prosthesis	251
D6602	Retainer inlay - cast high noble metal, two surfaces	344
D6603	Retainer inlay - cast high noble metal, >=3 surfaces	379
D6604	Retainer inlay - cast predominantly base metal, two surfaces	394
D6605	Retainer inlay - cast predominantly base metal, >=3 surfaces	379
D6606	Retainer inlay - cast noble metal, two surfaces	394
D6607	Retainer inlay - cast noble metal, >=3 surfaces	379
D6610	Retainer onlay - cast high noble metal, two surfaces	415

ADA CODE	DESCRIPTION	IN
D6611	Retainer onlay - cast high noble metal, >=3 surfaces	401
D6612	Retainer onlay - cast predominantly base metal, two surfaces	415
D6613	Retainer onlay - cast predominantly base metal, >=3 surfaces	401
D6614	Retainer onlay - cast noble metal, two surfaces	415
D6615	Retainer onlay - cast noble metal, >=3 surfaces	401
D6624	Retainer inlay - titanium	401
D6634	Retainer onlay - titanium	401
D6710	Retainer crown - indirect resin based composite	502
D6720	Retainer crown - resin with metal	446
D6721	Retainer crown - resin with metal	425
D6722	Retainer crown - resin with metal	425
D6740	Retainer crown - porcelain/ceramic	506
D6750	Retainer crown - porcelain fused to high noble metal	520
D6751	Retainer crown - porcelain fused to predominately base metal	475
D6752	Retainer crown - porcelain fused to noble metal	475
D6780	Retainer crown - 3/4 cast high noble metal	410
D6781	Retainer crown - 3/4 cast predominantly base metal	375
D6782	Retainer crown - 3/4 cast noble metal	404
D6790	Retainer crown - full cast high noble metal	512
D6791	Retainer crown - full cast predominately base metal	446
D6792	Retainer crown - full cast noble metal	473
D6793	Provisional retainer crown (if used at least 6 months during multistage care)	156
D6794	Retainer crown - titanium	502
D6930	Recement or rebond fixed partial denture	50
D6980	Fixed partial denture repair necessitated by restorative material failure	100

Class 3 - Oral Surgery

D7111	Extraction, coronal remnants - primary tooth	40
D7140	Extraction, erupted tooth or exposed root	50
D7210	Extraction, erupted tooth req elev, etc	104
D7220	Removal of impacted tooth - soft tissue	130
D7230	Removal of impacted tooth - partially bony	190
D7240	Removal of impacted tooth - completely bony	225
D7241	Removal of imp. tooth - completely bony, with unusual surg. complications	235
D7250	Removal of residual tooth roots	120
D7251	Coronectomy - intentional partial tooth removal (once per lifetime)	235
D7260	Oroantral fistula closure	689
D7261	Primary closure of a sinus perforation	200
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	414
D7285	Biopsy of oral tissue - hard (bone, tooth)	253
D7286	Biopsy of oral tissue - soft	259
D7287	Exfoliative cytological sample collection	50
D7288	Brush biopsy - transepithelial sample collection	40
D7310	Alveoloplastyin conjunction with extractions - per quad	201
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces per quadrant (once per quadrant)	132
D7320	Alveoloplasty not in conjunction with extractions - per quad	276
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces per quadrant (once per quadrant)	228
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	690
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrohpied and hyperplastic tissue)	1322
D7960	Frenulectomy (frenectomy/frenotomy) - separate proc	322
D7963	Frenuoplasty (once per site)	322
D7970	Excision of hyperplastic tissue - per arch	322
D7971	Excision of periocoronal gingiva	106
D7979	Non-surgical sialolithotomy	35
D7980	Surgical sialolithotomy	644
D7981	Excision of salivary gland, by report	2300
D7982	Sialodochoplasty	1380
D7983	Closure of salivary fistula	1196

Class 3 - Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain	35
D9120	Fixed partial denture sectioning (once per tooth)	35
D9210	Local anesthesia	14
D9222	Deep sedation/general anesthesia - first 15 minutes	58
D9223	Deep sedation/general anesthesia - each subsequent 15 min incr	58
D9239	Intravenous moderate sedation/analgesia – first 15 minutes	58
D9243	Intravenous moderate sedation/analgesia - each subsequent 15 min	58
D9248	Non-intravenous conscious sedation	89
D9310	Consultation (diagnostic service by nontreating dentist)	40
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	190
D9942	Repair or reline of an occlusal guard (only when D9940 has been benefited and after 6 months of initial placement)	82
D9944	Occlusal guard – hard appliance, full arch	220
D9945	Occlusal guard – soft appliance, full arch	220
D9946	Occlusal guard – hard appliance, partial arch	220
D9995	Teledentistry – synchronous; real-time encounter (when available)	20
D9996	Teledentistry – asynchronous; information store and forwarded to dentist for subsequent review (when available)	20

Class 4 - Orthodontics - Not covered 0%

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. 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) and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, 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.
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 Limitations

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. One full mouth or panoramic x-ray per 60 months
4. Periapical x-rays
5. Bitewing x-rays, 2 per calendar year
6. Two prophylaxis (cleaning, scaling and polishing teeth) per calendar year

Class II. Basic Services:

1. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months

Class III. Major Services:

1. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
2. 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
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place 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
3. Crown build-up for non-vital teeth
4. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Pulpotomy
   b. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
5. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
   d. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   e. One full mouth debridement per lifetime
   f. Two periodontal maintenance visits, following surgery per calendar year (D4341 is not considered surgery)
   g. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu or a covered D1120/D1110, limited to one per two years
6. 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
   e. One 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 years
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, periodontal surgery or implant placement procedures
9. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable, fixed appliance therapy and limited and comprehensive therapy.

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National (hereinafter referred to as Dominion).

DOMINION® NATIONAL DENTAL

Elite PPO Basic *Kids* (MD) Coverage Schedule, Limitations and Exclusions for Pediatric Services (under age 19)

- under age 19 (coverage continues through end of month 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	30%	None

Annual Deductible	In-Network	Out-of-Network
Single Child	$100	$100
Two or More Children	$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. For two or more children, the total combined maxmium deductible amount for all pediatric members is $200 per calendar year at which point the deductible is waived for remaining pediatric members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$350	N/A
Two or More Children	$700	N/A

- The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.

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, prior review is recommended.

Plan will pay either the participating dentist's negotiated fee or the 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 (D0120, D0145, D0150 or D0160) per calendar year, per patient per provider/location	100%	None	No	80%	None	No
1	Re-evaluation, limited, problem focused (D0170) or periodontal exam (D0180)	One per calendar year	100%	None	No	80%	None	No
1	Limited oral evaluation (D0140)		100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	Two per calendar year, per patient	100%	None	No	80%	None	No
1	Fluoride treatments	Four treatments are covered per calendar year, per patient, (ages 0-2 eight fluoride varnishes per calendar year, per patient) including topical application of fluoride	100%	None	No	80%	None	No
1	Bitewing x-rays	Two per calendar year, starting at age two, per provider/ location (D0270 does not have a frequency limitation)	100%	None	No	80%	None	No
1	Periapical x-rays		100%	None	No	80%	None	No
1	Full mouth x-ray or panoramic film	One per 36 months starting at age six; maximum of one set of x-rays per provider/location	100%	None	No	80%	None	No
1	Interim caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Space maintainers	One per 24 months, per quadrant (D1510 or D1520) or per arch (D1516, D1517, D1526 or D1527), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); D1575 limited to once per 24 months.	100%	None	No	80%	None	No
1	Sealants	One per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	100%	None	No	80%	None	No
1	Other diagnostic imaging (D0290, D0310, D0320, D0321)		100%	None	No	80%	None	No
1	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	No	80%	None	No
1	Pulp vitality tests		100%	None	No	80%	None	No
2	Amalgam and composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; per tooth, per surface every 36 months	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

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	Hospital call	Facility and anesthesia charges are covered under medical insurance; 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 services can be rendered	35%	None	Yes	20%	None	Yes
2	Occlusal guard	Limited to one (1) per 24 months, by report	35%	None	Yes	20%	None	Yes
2	General anesthesia and analgesic, including intravenous and non-intravenous sedation	General anesthesia is not covered with procedure codes D9230, D9239 or D9243; intravenous conscious sedation is not covered with procedure codes D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure codes D9222, D9223 or D9230; analgesia (nitrous oxide) is not covered with procedure codes D9222, D9223, D9239 or D9243; requires a narrative of medical necessity be maintained in patient records	35%	None	Yes	20%	None	Yes
3	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root or partial tooth	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, one (1) per lifetime	25%	None	Yes	10%	None	Yes
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:	Excision of a benign lesion, tumor or cyst and incision and drainage of an abscess or cyst	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Biopsy of oral tissue (D7285, D7286)	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy once per lifetime, per patient, per permanent tooth; Retreatment of previous root canal therapy, one per tooth, per lifetime, not within 24 months when done by same 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:	Pulpotomy; pulpal therapy; apexification/recalcification; apicoectomy; pulp caps (D3110 and D3120); root amputation (resection); hemisection	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	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, per root per lifetime	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Two periodontal maintenance visits per calendar year after definitive periodontal therapy	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Unscheduled dressing change (by someone other than their treating dentist or their staff)	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Root scaling and planing, once per 24 months, per patient, per quadrant	25%	None	Yes	10%	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 once per two years	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Occlusal adjustment, limited, if provided when no other restorative procedure on same date of service, limited to twice per twelve (12) months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Occlusal adjustment, complete, if provided when no other restorative procedure on same date of service, limited to once per twelve (12) months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months, per patient, per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Anatomical crown exposure and clinical lengthening	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 24 months, per patient, per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Provisional splinting	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	One pedicle or free soft tissue graft per site, per lifetime	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	One full mouth debridement per 24 months	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Localized delivery of antimicrobial agents is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per 12 months (must have pocket depths of five millimeters or greater)	25%	None	Yes	10%	None	Yes
3	Study model	One per 36 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	Restoration services, limited to:	Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite inlay, onlay, or crown for teeth 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 (D2930, D2932, D2933, D2934 one per 36 months from the original date of placement, per primary tooth, per patient)	25%	None	Yes	10%	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	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Protective restoration	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Post removal	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Core build-up one (1) per 60 months per tooth	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	One labial veneer per 60 months, per tooth	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Re-cement crowns/inlays	25%	None	Yes	10%	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 (1) per two (2) years.	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:	Repair of dentures twice per year and five total per five years	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after five years from the date of last placement	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Addition of teeth or clasp to existing partial denture	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Relining or rebasing of existing removable dentures; rebonding or recementing fixed denture	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Adjustment and maintenance of maxillofacial prosthetics, limited to D5992 and D5993, one each per patient, per six months, per arch	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Overdenture per 60 months, per arch	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Fabrication of athletic mouthguard	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	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Limited to two per calendar year	25%	None	Yes	10%	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	30%	None	No

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. Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Dispensing of drugs.
6. Hospitalization for the following: the operation or treatment for the fitting or wearing of dentures; orthodontic care or malocclusion, operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for the removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and dental implants.
7. 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.
8. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
9. Services not listed as covered.
10. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function. Bridges are not covered.
11. 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.
12. Treatment of cleft palate (if not treatable through orthodontics), malignancies or neoplasms.
13. 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.