



Smile More with Benefits
That Work for You



At Dominion National, we know you're unique. That's why we've designed customized plans and provide exceptional service, so you can thrive and focus on what truly matters to you.

WE WORK FOR THE BENEFIT OF OUR MEMBERS, DELIVERING:

EXTENSIVE NETWORKS²

Choice PPO network offers access to over 387,000 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.^{3,4}

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

SECURE ONLINE ACCESS

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



MEMBER PORTAL

DominionMembers.com



DOMINION NATIONAL GO MOBILE COMMUNICATION SERVICE

Register at DominionNational.com/go or by calling 888.596.0716



LIVE CHAT SUPPORT

Visit DominionNational.com to chat with a live agent.

VALUE-ADDED BENEFITS⁵

PREVENTION REWARDS PROGRAM

Get Cleanings. Get Rewarded!

Primary subscribers will receive a \$20 reward from Dominion for themselves and each enrolled family member who gets two cleanings in a calendar year from a participating dentist.

No extra steps are needed! Just visit your participating dentist twice a year for a cleaning, have them submit the claim, and Dominion will automatically send the reward check to the primary subscriber.

HEARING DISCOUNT PROGRAM

amplifonusa.com/dn

Access to discounts on hearing aids and services.⁶

Z DENTAL DISCOUNT

Myzsonic.com/DN

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



TOLL-FREE, 24 HOUR ACCESS at 888.518.5338

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

¹ Dominion National Network Analysis Report, 2024

² Networks and products vary by state. Check availability on your state marketplace.

³ Participating providers are subject to change.

⁴ Managed care plan with exclusive network, fixed member copayments, no annual maximum dollar limits, no waiting periods and no deductibles. In New Jersey, Select Plans are available in Camden, Cumberland and Gloucester counties only. Dominion National Network Analysis Report, 2023. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.

⁵ Notice of discount offerings is for informational purposes only and is not medical advice. Discount offerings are subject to change without notice.

⁶ Visit amplifonusa.com/dn for full details. Hearing services are administered by Amplifon Hearing Health Care Corp.

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



Choice PPO Basic (IL) Coverage Schedule, Limitations and Exclusions for Adult Services

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays ²	Waiting Period
		Y1 Y2 Y3 ¹		Y1 Y2 Y3 ¹	
1	Diagnostic & Preventive Services	100% 100% 100%	None	90% 90% 90%	None
2	Basic Services	50% 60% 80%	None	30% 50% 70%	None
3	Major Services	15% 25% 50%	None	10% 20% 40%	None
4	Orthodontic Services	0%	N/A	0%	N/A
1. The amount the plan pays for services increases from Year 1 to Year 3, with a maximum plan contribution in Year 3, provided that the member has continuous coverage during each year.					
Annual Deductible		In-Network		Out-of-Network	
Single Adult		\$50		\$50	
Three or More Adults		\$150		\$150	
Applies To		Class 1, Class 2, and Class 3		Class 1, Class 2, and Class 3	
<ul style="list-style-type: none">Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member’s dental procedures. There is a \$50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible. For three or more adults, the total combined maximum deductible amount for all adult Members is \$150 per Calendar Year at which point the deductible is waived for remaining adult Members.					
Maximums		In-Network		Out-of-Network	
Annual		\$1,000		\$1,000	
Lifetime Orthodontic		N/A		N/A	
<ul style="list-style-type: none">The maximum listed is the dollar amount that the plan will pay towards the cost of dental care within the specified period per memberThe annual maximum is combined for in-network and out-of-network services.The annual maximum applies to: Class 1, Class 2, Class 3					
Out-of-Network Allowance		In-Network		Out-of-Network	
		N/A		MAC	
2. 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 benefit coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
1	Evaluations	Two per Calendar Year including a maximum of one comprehensive evaluation per 36 months	Y1: 100% Y2: 100% Y3: 100%	None	\$50	Y1: 90% Y2: 90% Y3: 90%	None	\$50
1	Emergency or problem focused exam	One per Calendar Year	Y1: 100% Y2: 100% Y3: 100%	None	\$50	Y1: 90% Y2: 90% Y3: 90%	None	\$50
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	Y1: 100% Y2: 100% Y3: 100%	None	\$50	Y1: 90% Y2: 90% Y3: 90%	None	\$50
1	Prevention Rewards	Primary subscriber will receive a \$20 payment from Dominion for each family member that receives two cleanings during the Calendar Year from a participating Choice PPO network dentist	Y1: 100% Y2: 100% Y3: 100%	None	\$0	Y1: 90% Y2: 90% Y3: 90%	None	\$0
1	Bitewing x-rays	Two per Calendar Year	Y1: 100% Y2: 100% Y3: 100%	None	\$50	Y1: 90% Y2: 90% Y3: 90%	None	\$50
1	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service	Y1: 100% Y2: 100% Y3: 100%	None	\$50	Y1: 90% Y2: 90% Y3: 90%	None	\$50
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	Y1: 100% Y2: 100% Y3: 100%	None	\$50	Y1: 90% Y2: 90% Y3: 90%	None	\$50
2	Simple extraction of teeth		Y1: 50% Y2: 60% Y3: 80%	None	\$50	Y1: 30% Y2: 50% Y3: 70%	None	\$50
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months	Y1: 50% Y2: 60% Y3: 80%	None	\$50	Y1: 30% Y2: 50% Y3: 70%	None	\$50
2	Periapical x-rays		Y1: 50% Y2: 60% Y3: 80%	None	\$50	Y1: 30% Y2: 50% Y3: 70%	None	\$50
2	Full mouth or panoramic x-ray	One per 60 months	Y1: 50% Y2: 60% Y3: 80%	None	\$50	Y1: 30% Y2: 50% Y3: 70%	None	\$50
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	Y1: 50% Y2: 60% Y3: 80%	None	\$50	Y1: 30% Y2: 50% Y3: 70%	None	\$50
2	Antibiotic injections administered by a dentist		Y1: 50% Y2: 60% Y3: 80%	None	\$50	Y1: 30% Y2: 50% Y3: 70%	None	\$50

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
3	Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of pericoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/ or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst		Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal	One per tooth per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: root canal therapy	Not covered if pulp chamber was opened before effective date of coverage	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
3	Periodontic services, limited to: full mouth debridement	One per lifetime	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Periodontic services, limited to: scaling in presence of generalized moderate or severe gingival inflammation	Full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Study model	One per 36 months	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Crown build-up for non-vital teeth		Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Repair of dentures or fixed bridgework	One per 24 months	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Infiltration of sustained release therapeutic drug, per quadrant		Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Restoration services, limited to: cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown	Limited to a tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
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	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	One per two years	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
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	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
3	Prosthetic services, limited to: addition of teeth to existing partial denture	Per tooth	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
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)	Y1: 15% Y2: 25% Y3: 50%	None	\$50	Y1: 10% Y2: 20% Y3: 40%	None	\$50
4	Orthodontia Services Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

The plan excludes and will not reimburse for the following services or charges:

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

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Choice PPO Basic Kids (IL) Coverage Schedule, Limitations and Exclusions for Pediatric Services

Coverage continues through end of the year in which the Member turns 19

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays 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	
<ul style="list-style-type: none">Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is \$200 per Calendar Year at which point the deductible is waived for remaining pediatric members.The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.					
Out-of-Pocket Maximum for In-Network Covered Services					
Single Child		\$450			
Two or More Children		\$900			
<ul style="list-style-type: none">The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.					
Out-of-Network Allowance		In-Network		Out-of-Network	
		N/A		MAC	
1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.					

- If course of treatment is to exceed \$300, pre-authorization is required.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
1	Evaluations	One evaluation every six (6) months per dentist in an office setting. One evaluation every twelve (12) months per dentist in a school setting	100%	None	\$0	80%	None	\$0
1	Comprehensive oral evaluation	One evaluation per 36 months	100%	None	\$0	80%	None	\$0
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per day per provider or location	100%	None	\$0	80%	None	\$0
1	Prophylaxis/cleaning	One per six (6) months	100%	None	\$0	80%	None	\$0
1	Prevention Rewards	Primary subscriber will receive a \$20 payment from Dominion for each family member that receives two cleanings during the Calendar Year from a participating Choice PPO network dentist	100%	None	\$0	80%	None	\$0
1	Fluoride treatment, topical application	One per twelve (12) months	100%	None	\$0	80%	None	\$0
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once per twelve (12) months	100%	None	\$0	80%	None	\$0
1	Periapical x-rays	Not on the same date of service as a panoramic radiograph	100%	None	\$0	80%	None	\$0
1	Full mouth complete series or panoramic radiographic image	One per three (3) years	100%	None	\$0	80%	None	\$0
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer; one bilateral per arch or one unilateral per quadrant, per six (6) months; includes all adjustments in the first six (6) months after insertion	100%	None	\$0	80%	None	\$0
1	Sealants or preventive resin restoration	One per tooth per lifetime (limited to occlusal surfaces of permanent molar teeth without restorations or decay)	100%	None	\$0	80%	None	\$0
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	\$0	80%	None	\$0

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
2	Amalgam and composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; replacement of existing restorations will only be covered if at least 12 months have passed since the previous restoration was placed	35%	None	\$100	20%	None	\$100
2	Pin retention of fillings	Pin retention per tooth in addition to restoration	35%	None	\$100	20%	None	\$100
2	Crown build-up for non-vital teeth	Only when done in conjunction with a covered crown or bridge and only when necessitated by substantial loss of natural tooth structure	35%	None	\$100	20%	None	\$100
2	Cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	35%	None	\$100	20%	None	\$100
2	Placement of interim direct restoration		35%	None	\$100	20%	None	\$100
2	Prefabricated resin, resin composite, and stainless steel crown	Once per tooth, per 60 months	35%	None	\$100	20%	None	\$100
2	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service, limited one visit per day per provider/location	35%	None	\$100	20%	None	\$100
2	General anesthesia, including intravenous conscious sedation, non-intravenous conscious sedation or inhalation sedation, and nitrous oxide		35%	None	\$100	20%	None	\$100
2	Recement cast or prefabricated post and core, inlay, crown		35%	None	\$100	20%	None	\$100
2	Therapeutic parenteral drug administration		35%	None	\$100	20%	None	\$100
2	Diagnostic casts		35%	None	\$100	20%	None	\$100
3	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty (per quadrant); excision of pericoronal gingiva; removal of exostosis; incision and drainage of an abscess or cyst; surgical access of an unerupted tooth; placement of device to facilitate eruption of impacted tooth	25%	None	\$100	10%	None	\$100
3	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	25%	None	\$100	10%	None	\$100
3	Oral surgery, including postoperative care for:	Bone replacement graft for ridge preservation	25%	None	\$100	10%	None	\$100
3	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy, frenuloplasty	25%	None	\$100	10%	None	\$100

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; retreatment of previous root canal therapy, once per tooth	25%	None	\$100	10%	None	\$100
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation	25%	None	\$100	10%	None	\$100
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy, limited to primary teeth only	25%	None	\$100	10%	None	\$100
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth, limited to maximum three (3) visits; apicoectomy/periradicular surgery, limited to once per root	25%	None	\$100	10%	None	\$100
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical exposure of root and surgical repair of root resorption	25%	None	\$100	10%	None	\$100
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, limited to once per root	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Periodontal maintenance	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, once per 24 months per quadrant	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 24 months per quadrant	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	One pedicle or free soft tissue graft; subepithelial connective tissue graft	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Full mouth debridement, once per six (6) months	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Provisional splinting - intracoronal and extracoronal	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Bone replacement graft	25%	None	\$100	10%	None	\$100
3	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery	25%	None	\$100	10%	None	\$100
3	Crowns, limited to:	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 month per patient per tooth. Limited to permanent teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	25%	None	\$100	10%	None	\$100

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
3	Restoration services, limited to:	Inlay and onlay 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	25%	None	\$100	10%	None	\$100
3	Restoration services, limited to:	Crown, inlay, and onlay repair	25%	None	\$100	10%	None	\$100
3	Removable prosthodontic services, limited to:	Initial placement of complete or partial dentures (upper and lower); repair and adjustment of complete or partial dentures (upper and lower), limited to adjustments that are done more than six (6) months after a rebase, reline, or initial insertion of the denture; addition of teeth or clasp to existing partial denture - per tooth	25%	None	\$100	10%	None	\$100
3	Removable prosthodontic services, limited to:	Replacement of complete or partial dentures (upper and lower) that cannot be repaired after 5 years from the date of last placement	25%	None	\$100	10%	None	\$100
3	Removable prosthodontic services, limited to:	Denture reline, complete or partial denture, limited to once per denture per 24 months. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 months after the insertion of the denture.	25%	None	\$100	10%	None	\$100
3	Maxillofacial prosthetic services, limited to:	Services that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition and requires a narrative of medical necessity	25%	None	\$100	10%	None	\$100
3	Fixed prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	25%	None	\$100	10%	None	\$100
3	Fixed prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	25%	None	\$100	10%	None	\$100
3	Infiltration of sustained release therapeutic drug, per quadrant		25%	None	\$100	10%	None	\$100

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion. Coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index or meeting criteria for medical necessity.	50%	None	\$0	30%	None	\$0

Plan Exclusions

The plan excludes and will not reimburse for the following services or charges:

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