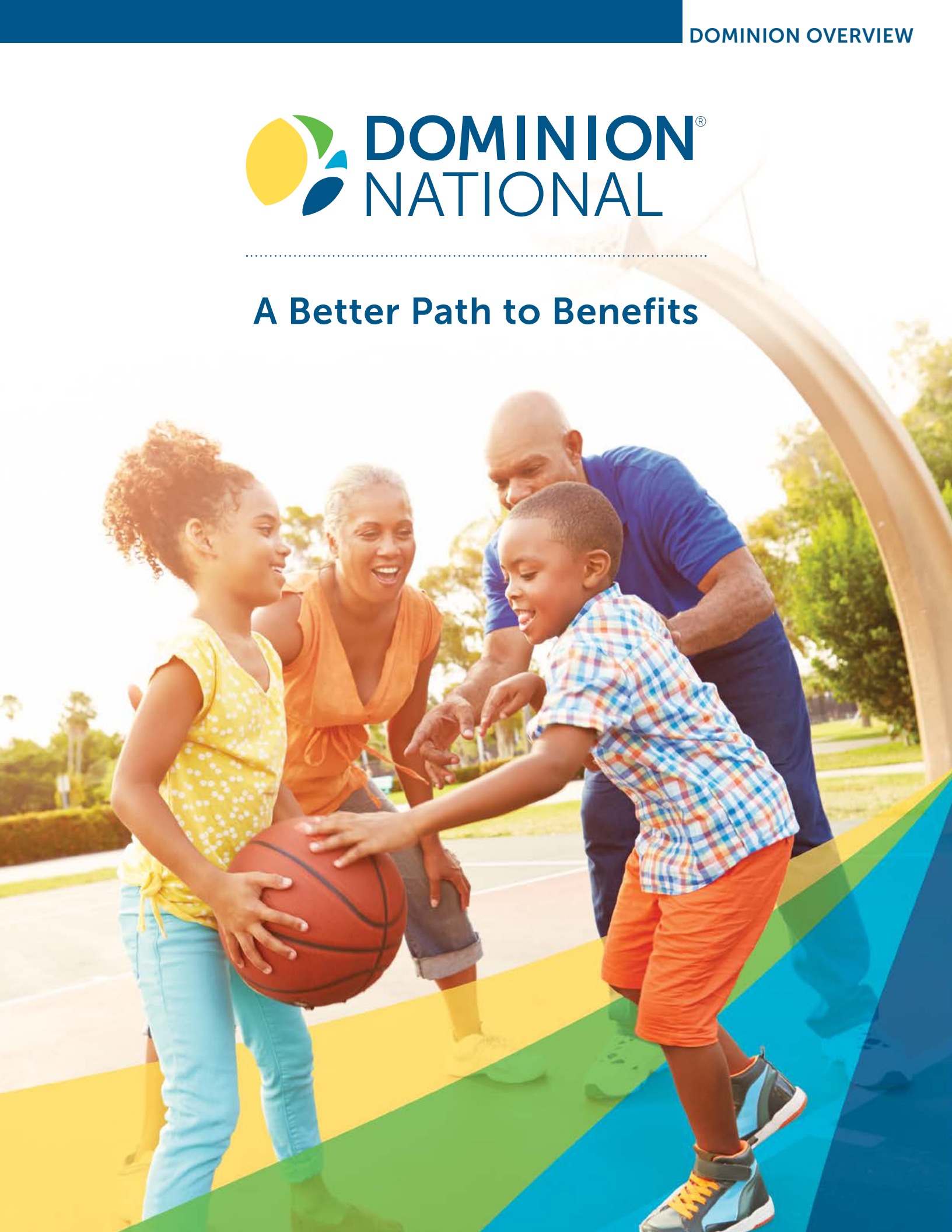




A Better Path to Benefits



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 NETWORKS²

Choice PPO network offers access to over 350,000 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**.

SECURE ONLINE ACCESS

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



MEMBER PORTAL

DominionMembers.com



GO MOBILE COMMUNICATION SERVICE

Register at DominionNational.com/go or by calling 888.596.0716



MYDOMINION MOBILE APP

Download at DominionNational.com/mobile



A COMMITMENT TO MEMBER SATISFACTION

In a recent Member Satisfaction Survey, 99% 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.

VALUE-ADDED BENEFITS

SMILEDIRECTCLUB⁶

DominionNational.com/sdc

Orthodontic clear aligners offer a cost-effective alternative to traditional braces.

HEARING DISCOUNT PROGRAM

amplifonusa.com/dn

Access to significant savings on hearing aids and services.⁷

1 Dominion National Internal Performance Report, 2020.

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

3 Participating providers are subject to change.

4 Dominion National Member Satisfaction Survey, October 2020.

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, 2020. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.

6 Cost of traditional braces based on average total fees for treatment of mild-to-moderate malocclusion. Data on file at SmileDirectClub. Not all individuals are suitable candidates for clear aligners. These services, which are offered and arranged for by SmileDirectClub, are intended for certain individuals who have mild or moderate orthodontic needs and only if approved by a state-licensed dentist or orthodontist. Dominion National is not a provider of dental care services. For complete details, visit DominionNational.com/sdc.

7 Based on Amplifon Hearing Health Care average member savings data for 2020. Pricing valid only at participating in-network locations. Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services and its own financial and contractual obligations. Hearing services are administered by Amplifon Hearing Health Care, Corp. Dominion National is not a provider of, nor provides coverage for, hearing health care services. For complete details, visit amplifonusa.com/dn.

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



Elite ePPO Premium (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	
<ul style="list-style-type: none"> • 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			
Rollover Services		Service Maximum (Paid by Plan)	Rollover Maximum
Maximum Amounts		\$750	\$1,875
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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	ADA CODE	DESCRIPTION	IN
Class 1 Diagnostic/Preventive			D0272	Bitewing x-rays - two radiographic images	0
D0120	Periodic oral eval - established patient	0	D0273	Bitewing x-rays - three radiographic images	0
D0140	Limited oral eval - problem focused	0	D0274	Bitewing x-rays - four radiographic images	0
D0150	Comprehensive oral eval - new or established patient	0	D0277	Vertical bitewings - 7 to 8 radiographic images	0
D0160	Detailed and extensive oral eval - problem focused ..	0	D0330	Panoramic radiographic image	0
D0170	Re-evaluation - limited, problem focused	0	D0340	2D cephalometric radiographic image	0
D0180	Comp. periodontal eval - new or established patient	0	D0350	2D oral/facial photographic images	0
D0210	Intraoral - complete series of radiographic images	0	D0460	Pulp vitality tests	0
D0220	Intraoral - periapical first radiographic image	0	D0701	Panoramic radiographic image – image capture only	0
D0230	Intraoral - periapical each add. radiographic image ..	0	D0702	2-D cephalometric radiographic image – image capture only	0
D0240	Intraoral - occlusal radiographic image	0	D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	0
D0250	Extraoral - 2D projection radiographic image	0	D0704	3-D photographic image – image capture only	0
D0270	Bitewing x-rays - single radiographic images	0			

ADA CODE	DESCRIPTION	IN	ADA CODE	DESCRIPTION	IN
D5621	Repair cast partial framework, mandibular	59	D6082	Implant supported crown – porcelain fused to predominantly base alloys	600
D5622	Repair cast partial framework, maxillary	59	D6083	Implant supported crown – porcelain fused to noble alloys	665
D5630	Clasp repaired, replaced or added	59	D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	640
D5640	Replace broken teeth - per tooth	65	D6086	Implant supported crown – predominantly base alloys	600
D5650	Add tooth to existing partial denture	65	D6087	Implant supported crown – noble alloys	620
D5660	Clasp repaired, replaced or added	70	D6088	Implant supported crown – titanium and titanium alloys	640
D5670	Replace all teeth and acrylic on cast metal framework	245	D6090	Repair implant supported prosthesis, by report (once in 12 months per tooth)	76
D5671	Replace all teeth and acrylic on cast metal framework	245	D6092	Recent implant/abutment supported crown (once per tooth after 6 months from initial placement)	24
D5710	Rebase complete maxillary/mandibular denture	185	D6093	Recent implant/abutment supported fixed partial denture (once in 12 months after 6 months from initial placement)	35
D5711	Rebase complete maxillary/mandibular denture	185	D6094	Abutment supported crown - titanium and titanium alloys	640
D5720	Rebase maxillary/mandibular partial denture	110	D6095	Repair implant abutment, by report (once per year after 24 months of initial placement)	140
D5721	Rebase maxillary/mandibular partial denture	110	D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	640
D5730	Reline complete maxillary/mandibular denture (direct)	93	D6100	Implant removal, by report (once per tooth)	116
D5731	Reline complete maxillary/mandibular denture (direct)	93	Class 3 Bridge & Pontics*		
D5740	Reline maxillary/mandibular partial denture (direct)	93	* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.		
D5741	Reline maxillary/mandibular partial denture (direct)	93	D6205	Pontic - indirect resin based composite	520
D5750	Reline complete maxillary/mandibular denture (indirect)	134	D6210	Pontic - cast high noble metal	510
D5751	Reline complete maxillary/mandibular denture (indirect)	134	D6211	Pontic - cast predominately base metal	463
D5760	Reline maxillary/mandibular partial denture (indirect)	134	D6212	Pontic - cast noble metal	473
D5761	Reline maxillary/mandibular partial denture (indirect)	134	D6214	Pontic - titanium and titanium alloys	520
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary/mandibular ..	228	D6240	Pontic - porcelain fused to high noble metal	570
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary/mandibular ..	228	D6241	Pontic - porcelain fused to predominately base metal	520
D5850	Tissue conditioning - maxillary/mandibular	41	D6242	Pontic - porcelain fused to noble metal	520
D5851	Tissue conditioning - maxillary/mandibular	41	D6243	Pontic – porcelain fused to titanium and titanium alloys	520
D5863	Overdenture – complete maxillary	600	D6245	Pontic - porcelain/ceramic	500
D5864	Overdenture – partial maxillary	565	D6250	Pontic - resin with high noble metal	552
D5865	Overdenture – complete mandibular	600	D6251	Pontic - resin with predominately base metal	442
D5866	Overdenture – partial mandibular	565	D6252	Pontic - resin with noble metal	508
Class 3 Implant Services			D6545	Retainer - cast metal for resin bonded fixed prosthesis	251
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	D6602	Retainer inlay - cast high noble metal, two surfaces ..	344
D6056	Prefabricated abutment (includes placement)	468	D6603	Retainer inlay - cast high noble metal, >=3 surfaces ..	379
D6057	Custom abutment (includes placement)	560	D6604	Retainer inlay - cast predominately base metal, two surfaces	394
D6058	Abutment supported porcelain/ceramic crown	705	D6605	Retainer inlay - cast predominately base metal, >=3 surfaces	379
D6059	Abutment supported porcelain fused to metal crown (high noble)	665	D6606	Retainer inlay - cast noble metal, two surfaces	394
D6060	Abutment supported porcelain fused to metal crown (base metal)	600	D6607	Retainer inlay - cast noble metal, >=3 surfaces	379
D6061	Abutment supported porcelain fused to metal crown (noble metal)	640	D6610	Retainer onlay - cast high noble metal, two surfaces ..	415
D6062	Abutment supported cast metal crown (high noble) ..	632	D6611	Retainer onlay - cast high noble metal, >=3 surfaces ..	401
D6063	Abutment supported cast metal crown (base metal) ..	600	D6612	Retainer onlay - cast predominately base metal, two surfaces	415
D6064	Abutment supported cast metal crown (noble metal)	620			
D6065	Implant supported porcelain/ceramic crown	705			
D6066	Implant supported crown - porcelain fused to high noble alloys	665			
D6067	Implant supported crown - high noble alloys	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			

ADA CODE	DESCRIPTION	IN	ADA CODE	DESCRIPTION	IN
D6613	Retainer onlay - cast predominantly base metal, >=3 surfaces	401	D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	1322
D6614	Retainer onlay - cast noble metal, two surfaces	415	D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	25
D6615	Retainer onlay - cast noble metal, >=3 surfaces	401	D7961	Buccal/labial frenectomy (frenulectomy)	322
D6624	Retainer inlay - titanium	401	D7962	Lingual frenectomy (frenulectomy)	322
D6634	Retainer onlay - titanium	401	D7963	Frenuoplasty (once per site)	322
D6710	Retainer crown - indirect resin based composite	502	D7970	Excision of hyperplastic tissue - per arch	322
D6720	Retainer crown - resin with metal	446	D7971	Excision of pericoronary gingiva	106
D6721	Retainer crown - resin with metal	425	D7979	Non-surgical sialolithotomy	35
D6722	Retainer crown - resin with metal	425	D7980	Surgical sialolithotomy	644
D6740	Retainer crown - porcelain/ceramic	506	D7981	Excision of salivary gland, by report	2300
D6750	Retainer crown - porcelain fused to high noble metal	520	D7982	Sialodochoplasty	1380
D6751	Retainer crown - porcelain fused to predominately base metal	475	D7983	Closure of salivary fistula	1196
D6752	Retainer crown - porcelain fused to noble metal	475			
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	502	Class 3 Adjunctive General Services		
D6780	Retainer crown - 3/4 cast high noble metal	410	D9110	Palliative (emergency) treatment of dental pain	35
D6781	Retainer crown - 3/4 cast predominantly base metal	375	D9120	Fixed partial denture sectioning (once per tooth)	35
D6782	Retainer crown - 3/4 cast noble metal	404	D9210	Local anesthesia	14
D6784	Retainer crown ¾ - titanium and titanium alloys	502	D9222	Deep sedation/general anesthesia - first 15 minutes	58
D6790	Retainer crown - full cast high noble metal	512	D9223	Deep sedation/general anesthesia - each subsequent 15 min incr	58
D6791	Retainer crown - full cast predominately base metal	446	D9239	Intravenous moderate sedation/analgesia - first 15 minutes	58
D6792	Retainer crown - full cast noble metal	473	D9243	Intravenous moderate sedation/analgesia- each subsequent 15 min	58
D6793	Provisional retainer crown (if used at least 6 months during multistage care)	156	D9248	Non-intravenous conscious sedation	89
D6794	Retainer crown - titanium and titanium alloys	502	D9310	Consultation (diagnostic service by nontreating dentist)	40
D6930	Recement or rebond fixed partial denture	50	D9613	Infiltration of sustained release therapeutic drug - single or multiple sites	190
D6980	Fixed partial denture repair necessitated by restorative material failure	100	D9942	Repair or relines 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)	0
			D9996	Teledentistry - asynchronous; information store and forwarded to dentist for subsequent review (when available)	0
			D9997	Dental case management - patients with special health care needs	50
			Class 4 Orthodontics - Not covered		0%
Class 3 Oral Surgery			Current Dental Terminology © American Dental Association. Only current ADA CDT codes are considered valid by Dominion. For a full description of each code, please consult the ADA's CDT guidelines.		
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	Alveoloplasty in 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			

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
 - g 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.
 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, or periodontal surgery, or implant placement procedures
 9. Teledentistry, synchronous (D9995) or asynchronous (D9996), must be accompanied by a covered procedure.

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable, fixed appliance therapy and limited and comprehensive therapy. One study model per 36 months.

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



**Elite PPO Premium 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	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	30%	None
Annual Deductible		In-Network		Out-of-Network	
Single Child		\$50		\$50	
Two or More Children		\$100		\$100	
Applies to		Class 2 and Class 3		Class 2 and Class 3	
<ul style="list-style-type: none"> 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 maximum deductible amount for all pediatric members is \$100 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		\$375		N/A	
Two or More Children		\$750		N/A	
<ul style="list-style-type: none"> 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	
<ol style="list-style-type: none"> 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)	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
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	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	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	None	Yes	60%	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 and 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	80%	None	Yes	60%	None	Yes
2	Occlusal guard		80%	None	Yes	60%	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	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root or partial tooth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, one (1) per tooth, per lifetime	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of periocoronary gingiva or hyperplastic tissue and excision of oral tissue for biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of a benign lesion, tumor or cyst and incision and drainage of an abscess or cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Biopsy of oral tissue (D7285, D7286)	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	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	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	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, per root per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Two periodontal maintenance visits following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Unscheduled dressing change (by someone other than treating dentist or their staff)	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, once per 24 months, per patient, per quadrant	80%	None	Yes	60%	None	Yes
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 D1120/D1110, limited to once per two years	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	None	Yes
2	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	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months, per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Anatomical crown exposure and clinical lengthening	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 24 months, per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle or free soft tissue graft per site, per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One full mouth debridement per 24 months	80%	None	Yes	60%	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:	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)	80%	None	Yes	60%	None	Yes
3	Study model	One per 36 months	50%	None	Yes	30%	None	Yes
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 (D2928, D2929, D2930, D2932, D2933, D2934 one per 36 months from the original date of placement, per primary tooth, per patient)	50%	None	Yes	30%	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	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Protective restoration	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Post removal	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Core build-up one (1) per 60 months per tooth	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	One labial veneer per 60 months, per tooth	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Re-cement crowns/inlays	50%	None	Yes	30%	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.	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures twice per year and five total per five years	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after five years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	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	Prosthetic services, limited to:	Relining or rebasing of existing removable dentures; rebonding or recementing fixed denture	50%	None	Yes	30%	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	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Overdenture per 60 months, per arch	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Fabrication of athletic mouthguard	50%	None	Yes	30%	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) 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.