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 NETWORKS[2]

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.**

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

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DominionMembers.com

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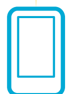
Register at DominionNational.com/go or by calling 888.596.0716



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

SmileDirectClub[6]
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.

Dominion National is the brand name for the Dominion group of companies. Dental plans are underwritten by Dominion Dental Services, Inc. (DDSI). Dominion Dental Services USA, Inc. (DDSUSA) is a licensed administrator of dental and vision benefits. Vision plans are underwritten by Avalon Insurance Company, and administered by DDSUSA, in DC, DE, MD, PA and VA. Vision Plans are underwritten by DDSI in all other states where Dominion National operates. The Discount Program is offered through DDSUSA.

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

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

Elite PPO Premium (MD)
Coverage Schedule, Limitations and Exclusions for Adult Services (age 19 and over)

- age 19 and over (coverage begins the first day of the month following the 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	90%	None
2	Basic Services	80%	6 months	70%	6 months
3	Major Services	50%	12 months	40%	12 months
4	Orthodontic Services	0%	N/A	0%	N/A

Annual Deductible	In-Network	Out-of-Network
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to	Class 2 and Class 3	Class 2 and Class 3

- 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	$1,500	$1,500
Lifetime Orthodontic	N/A	N/A

- The maximum listed is the dollar amount that the plan will pay towards the cost of dental care within the specified period per member.
- The annual maximum is combined for in-network and out-of-network services.
- The annual maximum applies to: Class 1, Class 2 and Class 3

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.

- Waiting period credit will be given for the length of time Member was covered under each benefit classification under their prior dental plan.
- 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 per Calendar year including a maxmium of one comprehensive evaluation per 36 months	100%	None	No	90%	None	No
1	Emergency or problem focused exam (D0140)	One per Calendar year	100%	None	No	90%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar year	100%	None	No	90%	None	No
1	Bitewing x-rays	Two per Calendar year	100%	None	No	90%	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	90%	None	No
1	Periapical x-rays		100%	None	No	90%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	90%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	90%	None	No
2	Simple extraction of teeth		80%	6	Yes	70%	6	Yes
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	80%	6	Yes	70%	6	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	6	Yes	70%	6	Yes
2	Antibiotic injections administered by a dentist		80%	6	Yes	70%	6	Yes
3	Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/ or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst		50%	12	Yes	40%	12	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal	One per tooth per lifetime	50%	12	Yes	40%	12	Yes
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	50%	12	Yes	40%	12	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		50%	12	Yes	40%	12	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	One per root per lifetime	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: full mouth debridement	One per lifetime	50%	12	Yes	40%	12	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 one per two years	50%	12	Yes	40%	12	Yes
3	Study model	One per 36 months	50%	12	Yes	40%	12	Yes
3	Crown build-up for non-vital teeth		50%	12	Yes	40%	12	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	50%	12	Yes	40%	12	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	50%	12	Yes	40%	12	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	50%	12	Yes	40%	12	Yes
3	Infiltration of sustained release therapeutic drug - single or multiple sites		50%	12	Yes	40%	12	Yes
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	50%	12	Yes	40%	12	Yes
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	50%	12	Yes	40%	12	Yes
3	Restoration services, limited to: post and core	Covered in addition to a crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	50%	12	Yes	40%	12	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	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	One per two years	50%	12	Yes	40%	12	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		50%	12	Yes	40%	12	Yes
3	Prosthetic services, limited to: replacement of removable dentures or fixed bridges	That cannot be repaired after 7 years from the date of last placement	50%	12	Yes	40%	12	Yes
3	Prosthetic services, limited to: addition of teeth to existing partial denture		50%	12	Yes	40%	12	Yes
3	Prosthetic services, limited to: relining or rebasing of existing removable dentures	One per 24 months (only after 24 months from date of last placement)	50%	12	Yes	40%	12	Yes
4	Orthodontia Services (medically necessary) 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

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) 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, 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 the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

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

- 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

- 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 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 periocoronal 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.