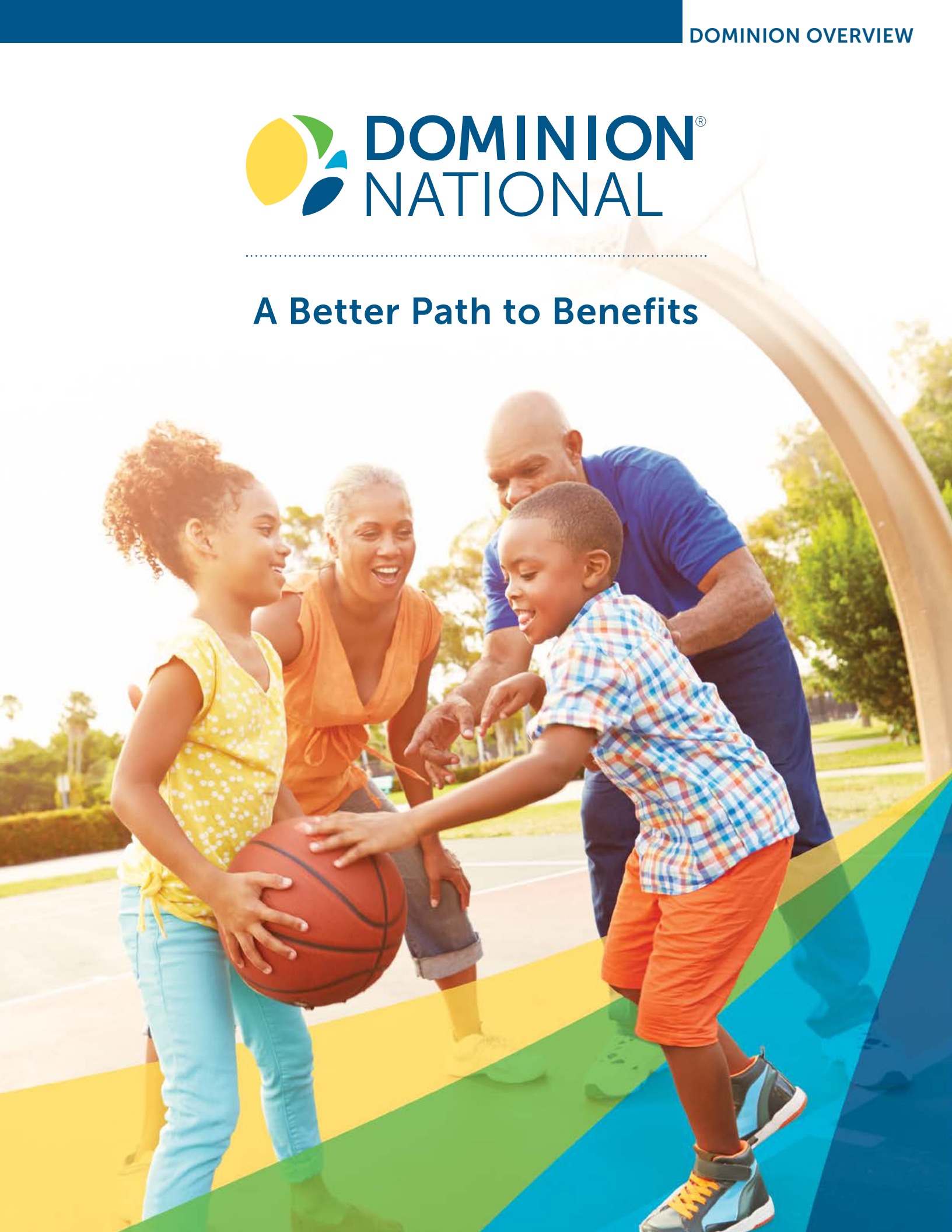




A Better Path to Benefits



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

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A COMMITMENT TO MEMBER SATISFACTION

In a recent Member Satisfaction Survey, 99% of the respondents were satisfied with Dominion as their dental plan.⁴



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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 Basic (PA) 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 (IN) providers have contracted with Dominion and accept the IN 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 image	0			

ADA CODE	DESCRIPTION	IN	ADA CODE	DESCRIPTION	IN
D0705	Extra-oral posterior dental radiographic image – image capture only	0	D2790	Crown - full cast high noble metal	507
D0706	Intraoral – occlusal radiographic image – image capture only	0	D2791	Crown - full cast predominately base metal	455
D0707	Intraoral – periapical radiographic image – image capture only	0	D2792	Crown - full cast noble metal	473
D0708	Intraoral – bitewing radiographic image – image capture only	0	D2794	Crown - titanium and titanium alloys	530
D0709	Intraoral – complete series of radiographic images – image capture only	0	D2910	Recement inlay, onlay/crown or partial coverage rest.	34
D0999	Chlorhexidine mouth rinse or fluoride toothpaste (twice per year for 2 years; covered only following scaling and root planing (a deep cleaning) and must be dispensed in the dentist's office)	0	D2915	Recement cast of prefabricated post and core (once in a lifetime)	34
D1110	Prophylaxis (cleaning) - adult	0	D2920	Recement inlay, onlay/crown or partial coverage rest.	27
Class 2 Restorative (Fillings)			D2930	Prefab. stainless steel crown - prim. tooth	90
D2140	Amalgam - one surface, prim. or perm.	20	D2931	Prefab. stainless steel crown - perm. tooth	90
D2150	Amalgam - two surfaces, prim. or perm.	30	D2932	Prefabricated resin crown	66
D2160	Amalgam - three surfaces, prim. or perm.	40	D2933	Prefabricated stainless steel crown with resin window (once every 24 months on anterior primary tooth)	84
D2161	Amalgam - >=4 surfaces, prim. or perm.	55	D2934	Prefabricated esthetic coated stainless steel crown - primary tooth (once every 24 months on anterior primary tooth)	84
D2330	Resin-based composite - one surface, anterior	32	D2940	Protective restoration	30
D2331	Resin-based composite - two surfaces, anterior	42	D2950	Core buildup, including any pins	100
D2332	Resin-based composite - three surfaces, anterior	52	D2951	Pin retention - per tooth, in addition to restoration ..	28
D2335	Resin-based composite - >=4 surfaces, anterior	100	D2952	Post and core in addition to crown	141
D2390	Resin-based composite crown, anterior	70	D2953	Each additional indirectly fabricated post, same tooth, indirectly fabricated	77
D2391	Resin-based composite - one surface, posterior	45	D2954	Prefab. post and core in addition to crown	105
D2392	Resin-based composite - two surfaces, posterior	55	D2961	Labial veneer (resin laminated) - indirect (not covered if considered cosmetic; once per 60 months)	285
D2393	Resin-based composite - three surfaces, posterior ..	65	D2962	Labial veneer (porcelain laminated) - indirect (not covered if considered cosmetic; once per 60 months)	436
D2394	Resin-based composite - >=4 surfaces, posterior	115	D2971	Additional procedures to construct new crown under existing partial denture framework (once per tooth per 60 months)	54
Class 3 Crown & Bridge*			D2980	Crown repair necessitated by restorative material failure	85
* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.			D2981	Inlay repair necessitated by restorative material failure	85
D2510	Inlay - metallic - one surface	261	D2982	Onlay repair necessitated by restorative material failure	85
D2520	Inlay - metallic - two surfaces	336	Class 3 Endodontics		
D2530	Inlay - metallic - three or more surfaces	375	D3110	Pulp cap - direct (excl. final restoration)	13
D2542	Onlay - metallic - two surfaces	355	D3120	Pulp cap - indirect (excl. final restoration)	13
D2543	Onlay - metallic - three surfaces	375	D3220	Therapeutic pulpotomy (excl. final restor.)	100
D2544	Onlay - metallic - four or more surfaces	391	D3221	Pulpal debridement, prim. and perm. teeth	100
D2610	Inlay - porcelain/ceramic - one surface	317	D3222	Partial pulpotomy for apexogenesis (once per permanent tooth per lifetime for patients under 19 years)	100
D2620	Inlay - porcelain/ceramic - two surfaces	331	D3230	Pulpal therapy (resorbable filling) anterior primary tooth (excluding final restoration and on primary molar without a permanent successor)	90
D2630	Inlay - porcelain/ceramic - >=3 surfaces	374	D3240	Pulpal therapy (resorbable filling) posterior primary tooth (excluding final restoration and on primary molar without a permanent successor)	102
D2642	Onlay - porcelain/ceramic - two surfaces	375	D3310	Endodontic therapy, anterior tooth (excl. final restor.)	550
D2643	Onlay - porcelain/ceramic - three surfaces	391	D3320	Endodontic therapy, premolar tooth (excl. final restor.)	640
D2644	Onlay - porcelain/ceramic - >=4 surfaces	393	D3330	Endodontic therapy, molar tooth (excl. final restor.) .	780
D2650	Inlay - resin-based composite - one surface	317	D3331	Treatment of root canal obstruction; non-surgical access	127
D2651	Inlay - resin-based composite - two surfaces	331	D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	234
D2652	Inlay - resin-based composite - >=3 surfaces	374	D3333	Internal root repair of perforation defects	119
D2662	Onlay - resin-based composite - two surfaces	375	D3346	Retreat of prev. root canal therapy - anterior	569
D2663	Onlay - resin-based composite - three surfaces	391	D3347	Retreat of prev root canal therapy - premolar	658
D2664	Onlay - resin-based composite - >=4 surfaces	393			
D2710	Crown - resin based composite (indirect)	433			
D2712	Crown - 3/4 resin-based composite (indirect)	433			
D2720	Crown - resin with high noble metal	465			
D2721	Crown - resin with predominately base metal	450			
D2722	Crown - resin with noble metal	450			
D2740	Crown - porcelain/ceramic	545			
D2750	Crown - porcelain fused to high noble metal	570			
D2751	Crown - porcelain fused to predominately base metal	520			
D2752	Crown - porcelain fused to noble metal	520			
D2780	Crown - 3/4 cast high noble metal	393			
D2781	Crown - 3/4 cast predominately base metal	368			
D2782	Crown - 3/4 cast noble metal	391			
D2783	Crown - 3/4 porcelain/ceramic	400			

ADA CODE	DESCRIPTION	IN	ADA CODE	DESCRIPTION	IN
D3348	Retreat of prev. root canal therapy - molar	776	D4276	Combined connective tissue and double pedicle graft (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	544
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) for permanent teeth and must follow 4-6 months of healing or narrowing of canal ..	170	D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	381
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) for permanent teeth and must follow 4-6 months of healing or narrowing of canal)	83	D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	30
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) ..	179	D4341	Perio scaling and root planing - >3 cont teeth, per quad	97
D3410	Apicoectomy - anterior	414	D4342	Perio scaling and root planing - <= 3 teeth, per quad	52
D3421	Apicoectomy - premolar (first root)	446	D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	30
D3425	Apicoectomy - molar (first root)	543	D4355	Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	60
D3426	Apicoectomy - (each add. root)	145	D4381	Localized delivery of antimicrobial agents	42
D3430	Retrograde filling - per root	138	D4910	Periodontal maintenance	75
D3450	Root amputation - per root	258	D4920	Unscheduled dressing change (by someone other than treating dentist)	49
D3471	Surgical repair of root resorption - anterior	414	Class 3 Prosthetics (Dentures)		
D3472	Surgical repair of root resorption – premolar	446	D5110	Complete denture - maxillary/mandibular	560
D3473	Surgical repair of root resorption – molar	543	D5120	Complete denture - maxillary/mandibular	560
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior..	414	D5130	Immediate denture - maxillary/mandibular	565
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	446	D5140	Immediate denture - maxillary/mandibular	565
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	543	D5211	Maxillary/mandibular partial denture - resin base ...	375
D3920	Hemisection, not inc. root canal therapy	194	D5212	Maxillary/mandibular partial denture - resin base ...	375
Class 3 Periodontics			D5213	Maxillary/mandibular partial denture - cast metal ...	625
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	198	D5214	Maxillary/mandibular partial denture - cast metal ...	625
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	100	D5221	Immediate maxillary partial denture - resin base	375
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	368	D5222	Immediate mandibular partial denture - resin base	375
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	221	D5223	Immediate maxillary partial denture - cast metal	625
D4249	Clinical crown lengthening - hard tissue (covered when bone removed, once per tooth per 60 months)	379	D5224	Immediate mandibular partial denture - cast metal	625
D4260	Osseous surgery - >3 cont. teeth, per quad	600	D5225	Maxillary/mandibular partial denture - flexible base	625
D4261	Osseous surgery - <=3 cont. teeth, per quad	360	D5226	Maxillary/mandibular partial denture - flexible base	625
D4263	Bone replacement graft - retained natural tooth - first site in quadrant (once per site per 36 months) ..	230	D5282	Rem. unilateral partial denture - one piece cast metal, maxillary	318
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant, not to exceed 2 sites in a quadrant (once per site per 36 months)	134	D5283	Rem. unilateral partial denture - one piece cast metal, mandibular	318
D4265	Biological materials to aid in soft and osseous tissue regeneration (once per site per 36 months)	194	D5284	Rem. unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	318
D4266	Guided tissue regeneration - resorbable barrier, per site (not to exceed 2 sites in a quadrant per 36 months)	341	D5286	Rem. unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	318
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal; not to exceed 2 sites in a quadrant per 36 months)	358	D5410	Adjust complete denture - maxillary/mandibular ...	20
D4270	Pedicle soft tissue graft procedure (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	401	D5411	Adjust complete denture - maxillary/mandibular ...	20
D4273	Autogenous connective tissue graft procedures (including donor site surgery; once per tooth per 36 months, not to exceed 2 teeth per 36 months)	626	D5421	Adjust partial denture - maxillary/mandibular	20
D4274	Mesial/distal wedge procedure, single tooth	194	D5422	Adjust partial denture - maxillary/mandibular	20
D4275	Non-autogenous connective tissue graft (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	405	D5511	Repair broken complete denture base, mandibular ..	59
			D5512	Repair broken complete denture base, maxillary	59
			D5520	Replace missing or broken teeth - complete denture	65
			D5611	Repair resin partial denture base, mandibular	59
			D5612	Repair resin partial denture base, maxillary	59
			D5621	Repair cast partial framework, mandibular	59
			D5622	Repair cast partial framework, maxillary	59
			D5630	Clasp repaired, replaced or added	59
			D5640	Replace broken teeth - per tooth	65
			D5650	Add tooth to existing partial denture	65
			D5660	Clasp repaired, replaced or added	70
			D5670	Replace all teeth and acrylic on cast metal framework	245
			D5671	Replace all teeth and acrylic on cast metal framework	245
			D5710	Rebase complete maxillary/mandibular denture	185

ADA CODE	DESCRIPTION	IN	ADA CODE	DESCRIPTION	IN
D5711	Rebase complete maxillary/mandibular denture	185	D6092	Recement implant/abutment supported crown (once per tooth after 6 months from initial placement)	24
D5720	Rebase maxillary/mandibular partial denture	110	D6093	Recement implant/abutment supported fixed partial denture (once in 12 months after 6 months from initial placement)	35
D5721	Rebase maxillary/mandibular partial denture	110	D6094	Abutment supported crown - titanium and titanium alloys	640
D5730	Reline complete maxillary/mandibular denture (direct)	93	D6095	Repair implant abutment, by report (once per year after 24 months of initial placement)	140
D5731	Reline complete maxillary/mandibular denture (direct)	93	D6100	Implant removal, by report (once per tooth)	116
D5740	Reline maxillary/mandibular partial denture (direct)	93	D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	640
D5741	Reline maxillary/mandibular partial denture (direct)	93			
D5750	Reline complete maxillary/mandibular denture (indirect)	134	Class 3 Bridge & Pontics*		
D5751	Reline complete maxillary/mandibular denture (indirect)	134		* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.	
D5760	Reline maxillary/mandibular partial denture (indirect)	134	D6205	Pontic - indirect resin based composite	520
D5761	Reline maxillary/mandibular partial denture (indirect)	134	D6210	Pontic - cast high noble metal	510
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary/mandibular	228	D6211	Pontic - cast predominately base metal	463
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary/mandibular	228	D6212	Pontic - cast noble metal	473
D5850	Tissue conditioning - maxillary/mandibular	41	D6214	Pontic - titanium and titanium alloys	520
D5851	Tissue conditioning - maxillary/mandibular	41	D6240	Pontic - porcelain fused to high noble metal	570
D5863	Overdenture – complete maxillary	600	D6241	Pontic - porcelain fused to predominately base metal	520
D5864	Overdenture – partial maxillary	565	D6242	Pontic - porcelain fused to noble metal	520
D5865	Overdenture – complete mandibular	600	D6243	Pontic – porcelain fused to titanium and titanium alloys	520
D5866	Overdenture – partial mandibular	565	D6245	Pontic - porcelain/ceramic	500
			D6250	Pontic - resin with high noble metal	552
Class 3 Implant Services			D6251	Pontic - resin with predominately base metal	442
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	D6252	Pontic - resin with noble metal	508
D6056	Prefabricated abutment (includes placement)	468	D6545	Retainer - cast metal for resin bonded fixed prosthesis	251
D6057	Custom abutment (includes placement)	560	D6602	Retainer inlay - cast high noble metal, two surfaces	344
D6058	Abutment supported porcelain/ceramic crown	705	D6603	Retainer inlay - cast high noble metal, >=3 surfaces	379
D6059	Abutment supported porcelain fused to metal crown (high noble)	665	D6604	Retainer inlay - cast predominantly base metal, two surfaces	394
D6060	Abutment supported porcelain fused to metal crown (base metal)	600	D6605	Retainer inlay - cast predominantly base metal, >=3 surfaces	379
D6061	Abutment supported porcelain fused to metal crown (noble metal)	640	D6606	Retainer inlay - cast noble metal, two surfaces	394
D6062	Abutment supported cast metal crown (high noble)	632	D6607	Retainer inlay - cast noble metal, >=3 surfaces	379
D6063	Abutment supported cast metal crown (base metal)	600	D6610	Retainer onlay - cast high noble metal, two surfaces	415
D6064	Abutment supported cast metal crown (noble metal)	620	D6611	Retainer onlay - cast high noble metal, >=3 surfaces	401
D6065	Implant supported porcelain/ceramic crown	705	D6612	Retainer onlay - cast predominantly base metal, two surfaces	415
D6066	Implant supported crown - porcelain fused to high noble alloys	665	D6613	Retainer onlay - cast predominantly base metal, >=3 surfaces	401
D6067	Implant supported crown - high noble alloys	665	D6614	Retainer onlay - cast noble metal, two surfaces	415
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	D6615	Retainer onlay - cast noble metal, >=3 surfaces	401
D6082	Implant supported crown – porcelain fused to predominantly base alloys	600	D6624	Retainer inlay - titanium	401
D6083	Implant supported crown – porcelain fused to noble alloys	665	D6634	Retainer onlay - titanium	401
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	640	D6710	Retainer crown - indirect resin based composite	502
D6086	Implant supported crown – predominantly base alloys	600	D6720	Retainer crown - resin with metal	446
D6087	Implant supported crown – noble alloys	620	D6721	Retainer crown - resin with metal	425
D6088	Implant supported crown – titanium and titanium alloys	640	D6722	Retainer crown - resin with metal	425
D6090	Repair implant supported prosthesis, by report (once in 12 months per tooth)	76	D6740	Retainer crown - porcelain/ceramic	506
			D6750	Retainer crown - porcelain fused to high noble metal	520
			D6751	Retainer crown - porcelain fused to predominately base metal	475
			D6752	Retainer crown - porcelain fused to noble metal	475
			D6753	Retainer crown – porcelain fused to titanium and titanium alloys	502
			D6780	Retainer crown - 3/4 cast high noble metal	410
			D6781	Retainer crown - 3/4 cast predominantly base metal	375

ADA CODE	DESCRIPTION	IN
D6782	Retainer crown - 3/4 cast noble metal	404
D6784	Retainer crown ¾ – titanium and titanium alloys	502
D6790	Retainer crown - full cast high noble metal	512
D6791	Retainer crown - full cast predominately base metal	446
D6792	Retainer crown - full cast noble metal	473
D6793	Provisional retainer crown (if used at least 6 months during multistage care)	156
D6794	Retainer crown - titanium and titanium alloys	502
D6930	Recement or rebond fixed partial denture	50
D6980	Fixed partial denture repair necessitated by restorative material failure	100
Class 3 Oral Surgery		
D7111	Extraction, coronal remnants - primary tooth	40
D7140	Extraction, erupted tooth or exposed root	50
D7210	Extraction, erupted tooth req elev, etc	104
D7220	Removal of impacted tooth - soft tissue	130
D7230	Removal of impacted tooth - partially bony	190
D7240	Removal of impacted tooth - completely bony	225
D7241	Removal of imp. tooth - completely bony, with unusual surg. complications	235
D7250	Removal of residual tooth roots	120
D7251	Coronectomy - intentional partial tooth removal (once per lifetime)	235
D7260	Oroantral fistula closure	689
D7261	Primary closure of a sinus perforation	200
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	414
D7285	Biopsy of oral tissue - hard (bone, tooth)	253
D7286	Biopsy of oral tissue - soft	259
D7287	Exfoliative cytological sample collection	50
D7288	Brush biopsy - transepithelial sample collection	40
D7310	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
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	1322
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	25
D7961	Buccal/labial frenectomy (frenulectomy)	322
D7962	Lingual frenectomy (frenulectomy)	322
D7963	Frenuoplasty (once per site)	322
D7970	Excision of hyperplastic tissue - per arch	322
D7971	Excision of periocoronary gingiva	106
D7979	Non-surgical sialolithotomy	35
D7980	Surgical sialolithotomy	644
D7981	Excision of salivary gland, by report	2300
D7982	Sialodochoplasty	1380
D7983	Closure of salivary fistula	1196
Class 3 Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain	35
D9120	Fixed partial denture sectioning (once per tooth)	35
D9210	Local anesthesia	14
D9222	Deep sedation/general anesthesia - first 15 minutes. 58	

ADA CODE	DESCRIPTION	IN
D9223	Deep sedation/general anesthesia - each subsequent 15 min incr	58
D9239	Intravenous moderate sedation/analgesia – first 15 minutes	58
D9243	Intravenous moderate sedation/analgesia- each subsequent 15 min	58
D9248	Non-intravenous conscious sedation	89
D9310	Consultation (diagnostic service by nontreating dentist)	40
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	190
D9942	Repair or relin 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

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.

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 are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

Plan Limitations

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months.
2. One emergency or problem focused exam (D0140) per Calendar Year.
3. One full mouth or panoramic x-ray per 60 months.
4. Periapical x-rays.
5. Bitewing x-rays, 2 per Calendar Year.
6. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year.

Class II. Basic Services:

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

Class III. Major Services:

1. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter.
2. Restoration services, limited to:
 - a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.

- b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced.
- c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally.
3. Crown build-up for non-vital teeth
4. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
 - a. Pulpotomy
 - b. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage).
 - c. Apicoectomy
 - d. Retrograde fillings, per root per lifetime
5. Periodontic services, limited to:
 - a. Gingivectomy
 - b. Osseous surgery including flap entry and closure
 - c. One pedicle or free soft tissue graft per site per lifetime
 - d. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
 - e. One full mouth debridement per lifetime
 - f. Two periodontal maintenance visits, following surgery per Calendar Year (D4341 is not considered surgery)
 - g. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu 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.

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



Elite PPO Basic Kids (PA)
Coverage Schedule, Limitations and Exclusions for Pediatric Services (under age 19)
 - under age 19 (coverage continues through end of month in which the Member turns 19) -

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays ¹	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	35%	None	20%	None
3	Major Services	25%	None	10%	None
4	Orthodontic Services	50%	None	0%	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 deductible amount for dental services before the plan will begin to cover the member's dental procedures. The deductible is combined for all applicable services for each calendar year per pediatric member - maximum \$200 for 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, 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)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One (1) evaluation (D0120, D0140, D0150 or D0180) per six (6) months, per patient; D0160 is covered.	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One (1) per six (6) months, per patient	100%	None	No	80%	None	No
1	Fluoride treatment	One (1) per six (6) months, per patient	100%	None	No	80%	None	No
1	Bitewing x-rays	One (1) set per six (6) months	100%	None	No	80%	None	No
1	Periapical x-rays	Not on the same date of service as a panoramic radiograph	100%	None	No	80%	None	No
1	Full mouth x-ray or panoramic film	One (1) per 60 months; maximum of one (1) set of x-rays per office visit	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 maintainer (D1516, D1517, D1526 or D1527)	To preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); D1575 limited to one (1) per 24 months	100%	None	No	80%	None	No
1	Sealants	One (1) per tooth per 36 months (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	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	35%	None	Yes	20%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one (1) pin	35%	None	Yes	20%	None	Yes
2	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service	35%	None	Yes	20%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
2	General anesthesia and analgesic	Only when provided in connection with a covered procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions, including intravenous and non-intravenous sedation with a maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure codes D9230, D9239 or D9243; intravenous conscious sedation is not covered with procedure code D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure code D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	35%	None	Yes	20%	None	Yes
2	Occlusal guard	Analysis and limited/complete adjustment, one (1) in 12 months for patients 13 and older, by report	35%	None	Yes	20%	None	Yes
2	Prefabricated stainless steel or porcelain crown	One (1) per 60 months from the original date of placement, per permanent tooth, per patient for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	35%	None	Yes	20%	None	Yes
2	Addition of teeth to existing partial denture		35%	None	Yes	20%	None	Yes
2	Relining or rebasing of existing removable dentures	One (1) per 36 months; only after six (6) months from date of last placement, unless an immediate prosthesis replacing at least three (3) teeth	35%	None	Yes	20%	None	Yes
2	Repair of crowns, dentures and bridges		35%	None	Yes	20%	None	Yes
3	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Extraction of tooth root	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, one per lifetime	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, and frenectomy	25%	None	Yes	10%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Oral surgery, including postoperative care for:	Excision of periocoronary gingiva, exostosis or hyperplastic tissue, and excision of oral tissue for biopsy	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Excision of a tumor or cyst and incision and drainage of an abscess or cyst	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; retreatment of previous root canal therapy	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy; apicoectomy	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, one (1) per root per lifetime	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Two (2) periodontal cleanings, in addition to adult prophylaxis, per calendar year, within 24 months after definitive periodontal therapy	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Root scaling and planing, one (1) per 24 months, per quadrant, per patient	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110/ D1120, limited to one (1) per two years	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingivectomy, one (1) per 36 months per patient, per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Osseous surgery including flap entry and closure, one (1) per 36 months per patient, per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Pedicle or free soft tissue graft	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Full mouth debridement, one (1) per lifetime	25%	None	Yes	10%	None	Yes
3	Study model	One (1) per 36 months	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite onlay, or crown for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one (1) per 60 months from the original date of placement, per permanent tooth, per patient.	25%	None	Yes	10%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Restoration services, limited to:	Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally; protective restoration; post removal; crown buildup for non-vital teeth	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after five (5) years from the date of last placement	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Construction of bridges, replacement limited to one (1) per 60 months	25%	None	Yes	10%	None	Yes
3	Implants and related services	Replacement of implant crowns limited to one (1) in 60 months	25%	None	Yes	10%	None	Yes
3	Implants and related services	One (1) 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 (2) years.	25%	None	Yes	10%	None	Yes
3	Infiltration of sustained release therapeutic drug - single or multiple sites		25%	None	Yes	10%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion.	50%	None	No	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. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
4. Oral surgery requiring the setting of fractures or 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 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.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services related to the treatment of TMD (Temporomandibular Disorder).
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth including third molars. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review.
12. Services not listed as covered.
13. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions except if the developmental malformation and/or congenital conditions cause severe, dysfunctional handicapping malocclusion that requires medically necessary orthodontia services.
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 (if not treatable through orthodontics), malignancies or neoplasms.
17. 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.