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

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (DC) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	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. The deductible is combined for all applicable services for each calendar year per pediatric member - maximum $100 for pediatric members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$400	N/A
Two or More Children	$800	N/A

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

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, prior review is recommended.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One evaluation (D0120, D0140, D0150, D0160 or D0180) per six (6) months, per patient. D0150 limited to once per 12 months	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months, per patient	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months, per patient	100%	None	No	80%	None	No
1	Bitewing x-rays	One set per six (6) months, starting at age two	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 per 60 months (starting at age six); maximum of one 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	One per 24 months per patient per arch (D1516, D1517, D1525 or D1527) to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); one distal shoe space maintainer (D1575), fixed, unilateral per lifetime.	100%	None	No	80%	None	No
1	Sealants	One 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	One per tooth per surface every 36 months (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	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
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	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	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 codes D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure codes D9222, D9223 or D9230); requires a narrative of medical necessity be maintained in patient records	80%	None	Yes	60%	None	Yes
2	Occlusal guard	Analysis and limited/complete adjustment, one in 12 months for patients 13 and older, by report	80%	None	Yes	60%	None	Yes
2	Prefabricated stainless steel or porcelain crown	One 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	80%	None	Yes	60%	None	Yes
2	Addition of teeth to existing partial denture		80%	None	Yes	60%	None	Yes
2	Relining or rebasing of existing removable dentures	One per 36 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth)	80%	None	Yes	60%	None	Yes
2	Repair of crowns, dentures and bridges	Twice per year and five total per 5 years	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, and frenectomy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of periocoronal gingiva, exostosis, or hyper plastic 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 tumor or cyst and incision and drainage of an abscess or cyst, Marsupialization of odontogenic cyst	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	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, impacted teeth only, one per lifetime	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 lifetime, not within 24 months when done by same dentist or dental office	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy; apicoectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, one per root per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Periodontal cleanings, two per calendar year, in addition to adult prophylaxis, within 24 months after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, once per 24 months per quadrant per patient	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 D1110/D1120, limited to once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, once per 36 months per patient, per quadrant and gingival irrigation with a medicinal agent, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 36 months per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle or free soft tissue graft, one per site per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per lifetime	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 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	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	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	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:	Replacement of dentures that cannot be repaired after 5 years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction of bridges, replacement limited to once per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Replacement of implant crowns limited to once per 60 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		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	0%	None	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.

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (DE) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	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. The deductible is combined for all applicable services for each calendar year per pediatric member - maximum $100 for pediatric members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$400	N/A
Two or More Children	$800	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 required.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One evaluation (D0120, D0145, D0150 or D0160) per six (6) months	100%	None	No	80%	None	No
1	Limited evaluation or re-evaluation, problem focused	One (D0140 or D0170) per twelve (12) months	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Four films per six (6) month	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 per 36 months	100%	None	No	80%	None	No
1	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Space maintainer	One fixed space maintainer (D1510, D1516, D1517) per 5 years, per arch to age 14, to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer (cannot be billed by the provider or practice that placed the appliance); one distal shoe space maintainer (D1575), fixed, unilateral per lifetime.	100%	None	No	80%	None	No
1	Sealants	One per tooth per 60 months, to age 16 (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	One per tooth per surface every 24 months (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations); sedative fillings when not billed on the same day as a normal restoration	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
2	Crown build-up	Coverage for non-vital teeth	80%	None	Yes	60%	None	Yes
2	Post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	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	Prefabricated crowns	One per tooth, per 60 months	80%	None	Yes	60%	None	Yes
2	Temporary crowns for a fractured tooth		80%	None	Yes	60%	None	Yes
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous and nonintravenous sedation	Maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure code 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 or D9230; analgesia (nitrous oxide) is not covered with procedure code D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	80%	None	Yes	60%	None	Yes
2	Occlusal guard	One per 24 months with covered surgery	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay, crown		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth except the surgical removal of 3rd molars	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root or partial tooth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty, limited to ages 14-18	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, limited to ages 14-18	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:	Incision and drainage of an abscess or cyst, marsupialization of odontogenic 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	Oral surgery, including postoperative care for:	Mobilization of erupted or malpositioned tooth, covered for all teeth except 3rd molars	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	Oral surgery, including postoperative care for:	Placement of device to facilitate eruption of impacted tooth (indicate if orthodontia related)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Sutures, limited to ages 14-18	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 permanent tooth; retreatment of previous root canal therapy, once per lifetime, not within 24 months when done by same dentist or dental office	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy and pulpal debridement; pulpal therapy and regeneration	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification (endodontists only), limited to ages 6-16; apicoectomy	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 cleanings following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One (1) scaling and root planing per quadrant, per 24 months	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:	Gingivectomy, once per quadrant, per 24 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per quadrant, per 24 months	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, free soft tissue, subepithelial connective tissue or double pedicle graft per site	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration (natural teeth - resorbable and non-resorbable barriers, per site) and biologic materials to aid in osseous tissue regeneration	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:	Mesial/distal wedge procedure, single tooth	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Soft tissue allograft	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel, provisional, porcelain/ ceramic, all ceramic and resin-based composite 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	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 5 years	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after 5 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
3	Prosthetic services, limited to:	One relining of existing removable dentures; or rebonding or recementing fixed denture; per 24 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); reline of custom sleep apnea appliance (indirect)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Obturator prosthesis and modification, mandibular resection prosthesis or trismus appliance	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Fluoride and/or topical medication carrier for patients undergoing radiation treatment	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning (not covered when performed within 6 months of any denture)	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		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?
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 as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
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.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (FL) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One per six (6) months	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis/cleaning	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment, topical application	Two per twelve (12) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one 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 per 60 months	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restoration	One per tooth per 36 months (limited to occlusal surfaces of permanent molar 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	Composite resin restorations limited to anterior teeth only; coverage for resins on posterior teeth is limited to the corresponding amalgam benefit	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Per tooth, only in conjunction with a permanent amalgam or composite filling restoration	80%	None	Yes	60%	None	Yes
2	Crown build-up for non-vital teeth and cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	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	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown	Once per tooth, per 60 months; prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration	80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment or after-hours office visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide	Must be administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay or onlay, crown, bridge		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration		80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; excision of hyperplastic tissue, vestibuloplasty	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:	Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy and retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, direct and indirect (includes sedative filling); pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation; hemisection, including any root removal	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:	Pulpal therapy limited to primary teeth only	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Incomplete endodontic therapy, inoperable or fractured tooth	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal maintenance or prophylaxis following surgery per 12 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening - hard tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Subepithelial connective tissue graft procedure	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement, once per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per 36 months when tooth is present	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Surgical revision procedure, per tooth, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration, once per 36 months when tooth is present	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?
3	Restoration services, limited to:	Cast metal, resin-based or porcelain/ceramic inlay, onlay, and crown for permanent tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Labial veneers	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown, inlay, onlay and veneer repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Simple stress breakers, per unit	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline full or partial denture limited to once per 36 months; denture rebases or relines done within 6 months are considered to be part of the denture placement when the rebase or reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 months after the insertion of the denture.	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns and retainer for fixed partial denture, abutment supported crown and retainer for fixed partial denture, bridges, complete dentures, and/or partial dentures; implant/abutment supported removable denture for completely or partially edentulous arch, implant/abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 months	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	Implants and related services	Surgical placement of implant body, endosteal implant; surgical placement of eposteal or transosteal implant	50%	None	Yes	30%	None	Yes
3	Implants and related services	Radiographs/surgical implant index, limited to once per arch per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Repair implant supported prosthesis, abutment and implant removal	50%	None	Yes	30%	None	Yes
3	Occlusal guards	Limited to one per 12 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion with prior authorization	50%	None	No	30%	None	No

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. 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 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. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (GA) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	100%	None
2	Basic Services	80%	None	80%	None
3	Major Services	50%	None	50%	None
4	Orthodontic Services	50%	None	50%	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, Class 3 and Class 4

- 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 $100 for pediatric members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$400	N/A
Two or More Children	$800	N/A

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

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, prior review is recommended.

Plan will pay either the participating dentist's negotiated fee or the maximum allowable charge (subject to service coverage percentage) for dental procedures and services as shown below, after any required annual deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One evaluation (D0120, D0145, D0150 or D0160) per six (6) months	100%	None	No	100%	None	No
1	Limited evaluation or re-evaluation, problem focused (D0140 or D0170)	One per six (6) months	100%	None	No	100%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	100%	None	No
1	Fluoride treatment	One per six (6) months	100%	None	No	100%	None	No
1	Bitewing x-rays	One set per six (6) months	100%	None	No	100%	None	No
1	Periapical x-rays	Not on the same date of service as a panoramic radiograph	100%	None	No	100%	None	No
1	Full mouth x-ray or panoramic film	One per 36 months	100%	None	No	100%	None	No
1	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	100%	None	No
1	Space maintainer	Space maintainer (D1510, D1516 or D1517) to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer	100%	None	No	100%	None	No
1	Sealants	One per tooth per 36 months (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	100%	None	No	100%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	100%	None	No
2	Amalgam and composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; sedative fillings when not billed on the same day as a normal restoration	80%	None	Yes	80%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	None	Yes	80%	None	Yes
2	Crown build-up for non-vital teeth		80%	None	Yes	80%	None	Yes
2	Post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and peridontally	80%	None	Yes	80%	None	Yes
2	Prefabricated and stainless steel crown	Once per tooth, per 60 months	80%	None	Yes	80%	None	Yes
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	80%	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, including intravenous and non-intravenous sedation	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 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	80%	None	Yes
2	Recement cast or prefabricated post and core, inlay, crown		80%	None	Yes	80%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	80%	None	Yes	80%	None	Yes
2	Pulp vitality test		80%	None	Yes	80%	None	Yes
2	Diagnostic casts		80%	None	Yes	80%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, except the surgical removal of 3rd molars	80%	None	Yes	80%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root or partial tooth	80%	None	Yes	80%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, impacted teeth only, one per lifetime	80%	None	Yes	80%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	Yes	80%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy, once per lifetime per permanent tooth; retreatment of previous root canal therapy, once per lifetime, not within 24 months when done by same dentist or dental office	80%	None	Yes	80%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy and pulpal debridement; pulpal therapy; root amputation	80%	None	Yes	80%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy and periradicular surgery	80%	None	Yes	80%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, one per root, per lifetime	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Four periodontal cleanings following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, once per 24 months per quadrant	80%	None	Yes	80%	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:	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 once per two years	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, once per 24 months per quadrant	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 24 months per quadrant	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site per 36 months	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per 36 months	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per quadrant, per 36 months	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration (natural teeth - resorbable and non-resorbable barriers, per site) and biologic materials to aid in osseous tissue regeneration	80%	None	Yes	80%	None	Yes
2	Periodontic services, limited to:	Soft tissue allograft, once per quadrant, per 36 months	80%	None	Yes	80%	None	Yes
3	Restoration services, limited to:	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; one per 60 months from the original date of placement, per permanent tooth, per patient	50%	None	Yes	50%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures; repair of dentures; addition of teeth or clasp to existing partial denture	50%	None	Yes	50%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after 5 years from the date of last placement	50%	None	Yes	50%	None	Yes
3	Prosthetic services, limited to:	One relining of existing removable dentures; or rebonding or recementing fixed denture; per 24 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); Reline of custom sleep apnea appliance (indirect)	50%	None	Yes	50%	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:	Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months	50%	None	Yes	50%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning (not covered when performed within 6 months of any denture)	50%	None	Yes	50%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns, abutments, bridges, complete dentures, and/or partial dentures. Limited to 1 per tooth every 5 years.	50%	None	Yes	50%	None	Yes
3	Scaling and debridement in the presence of inflammation or mucositis of a single implant	One (1) per two (2) years, including cleaning of the implant surfaces, without flap entry and closure	50%	None	Yes	50%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	50%	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	50%	None	Yes

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 as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
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, as determined by the Plan. 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.

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

DOMINION® NATIONAL DENTAL

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

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
1	Evaluations	One evaluation every six (6) months per dentist in an office setting. One evaluation every twelve (12) months per dentist in a school setting	100%	None	$0	80%	None	$0
1	Comprehensive oral evaluation	One evaluation per 36 months	100%	None	$0	80%	None	$0
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per day per provider or location	100%	None	$0	80%	None	$0
1	Prophylaxis/cleaning	One per six (6) months	100%	None	$0	80%	None	$0
1	Fluoride treatment, topical application	One per twelve (12) months	100%	None	$0	80%	None	$0
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once per twelve (12) months	100%	None	$0	80%	None	$0
1	Periapical x-rays	Not on the same date of service as a panoramic radiograph	100%	None	$0	80%	None	$0
1	Full mouth complete series or panoramic radiographic image	One per three (3) years	100%	None	$0	80%	None	$0
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer; one bilateral per arch or one unilateral per quadrant, per six (6) months; includes all adjustments in the first six (6) months after insertion	100%	None	$0	80%	None	$0
1	Sealants or preventive resin restoration	One per tooth per lifetime (limited to occlusal surfaces of permanent molar teeth without restorations or decay)	100%	None	$0	80%	None	$0
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	$0	80%	None	$0
2	Amalgam and composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; replacement of existing restorations will only be covered if at least 12 months have passed since the previous restoration was placed	80%	None	$50	60%	None	$50

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
2	Pin retention of fillings	Pin retention per tooth in addition to restoration	80%	None	$50	60%	None	$50
2	Crown build-up for non-vital teeth	Only when done in conjunction with a covered crown or bridge and only when necessitated by substantial loss of natural tooth structure	80%	None	$50	60%	None	$50
2	Cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	80%	None	$50	60%	None	$50
2	Protective restoration (sedative filling)		80%	None	$50	60%	None	$50
2	Prefabricated resin, resin composite, and stainless steel crown	Once per tooth, per 60 months	80%	None	$50	60%	None	$50
2	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service, limited one visit per day per provider/ location	80%	None	$50	60%	None	$50
2	General anesthesia, including intravenous conscious sedation, non-intravenous conscious sedation or inhalation sedation, and nitrous oxide		80%	None	$50	60%	None	$50
2	Recement cast or prefabricated post and core, inlay, crown		80%	None	$50	60%	None	$50
2	Therapeutic parenteral drug administration		80%	None	$50	60%	None	$50
2	Diagnostic casts		80%	None	$50	60%	None	$50
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty (per quadrant); excision of periocoronal gingiva; removal of exostosis; incision and drainage of an abscess or cyst; surgical access of an unerupted tooth; placement of device to facilitate eruption of impacted tooth	80%	None	$50	60%	None	$50
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	$50	60%	None	$50
2	Oral surgery, including postoperative care for:	Bone replacement graft for ridge preservation	80%	None	$50	60%	None	$50
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy, frenuloplasty	80%	None	$50	60%	None	$50
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; retreatment of previous root canal therapy, once per tooth	80%	None	$50	60%	None	$50

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation	80%	None	$50	60%	None	$50
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy, limited to primary teeth only	80%	None	$50	60%	None	$50
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth, limited to maximum three (3) visits; apicoectomy/ periradicular surgery, limited to once per root	80%	None	$50	60%	None	$50
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical exposure of root and surgical repair of root resorption	80%	None	$50	60%	None	$50
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, limited to once per root	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Periodontal maintenance	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, once per 24 months per quadrant	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 24 months per quadrant	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	One pedicle or free soft tissue graft; subepithelial connective tissue graft	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Full mouth debridement, once per six (6) months	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Provisional splinting - intracoronal and extracoronal	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Bone replacement graft	80%	None	$50	60%	None	$50
2	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery	80%	None	$50	60%	None	$50
3	Crowns, limited to:	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 month per patient per tooth. Limited to permanent teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	$50	30%	None	$50

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
3	Restoration services, limited to:	Inlay and onlay for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one per 60 months from the original date of placement, per permanent tooth, per patient	50%	None	$50	30%	None	$50
3	Restoration services, limited to:	Crown, inlay, and onlay repair	50%	None	$50	30%	None	$50
3	Removable prosthodontic services, limited to:	Initial placement of complete or partial dentures (upper and lower); repair and adjustment of complete or partial dentures (upper and lower), limited to adjustments that are done more than six (6) months after a rebase, reline, or initial insertion of the denture; addition of teeth or clasp to existing partial denture	50%	None	$50	30%	None	$50
3	Removable prosthodontic services, limited to:	Replacement of complete or partial dentures (upper and lower) that cannot be repaired after 5 years from the date of last placement	50%	None	$50	30%	None	$50
3	Removable prosthodontic services, limited to:	Denture reline, complete or partial denture, limited to once per denture per 24 months. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 months after the insertion of the denture.	50%	None	$50	30%	None	$50
3	Maxillofacial prosthetic services, limited to:	Services that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition and requires a narrative of medical necessity	50%	None	$50	30%	None	$50
3	Fixed prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	50%	None	$50	30%	None	$50

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Deductible Amount	Plan Pays	Waiting Period (Months)	Deductible Amount
3	Fixed prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	50%	None	$50	30%	None	$50
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	$50	30%	None	$50
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion. Coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index or meeting criteria for medical necessity.	50%	None	$0	30%	None	$0

Plan Exclusions

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

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

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (IN) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One per six (6) months	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis/cleaning	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment, topical application	Two per twelve (12) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one 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 per 60 months	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restoration	One per tooth per 36 months (limited to occlusal surfaces of permanent molar 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	Composite resin restorations limited to anterior teeth only; coverage for resins on posterior teeth is limited to the corresponding amalgam benefit	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Per tooth, only in conjunction with a permanent amalgam or composite filling restoration	80%	None	Yes	60%	None	Yes
2	Crown build-up for non-vital teeth and cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	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	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown	Once per tooth, per 60 months; prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration	80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment or after-hours office visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide	Must be administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay or onlay, crown, bridge		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration		80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; excision of hyperplastic tissue, vestibuloplasty	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:	Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy and retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, direct and indirect (includes sedative filling); pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation; hemisection, including any root removal	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:	Pulpal therapy limited to primary teeth only	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Incomplete endodontic therapy, inoperable or fractured tooth	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal maintenance or prophylaxis following surgery per 12 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening - hard tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Subepithelial connective tissue graft procedure	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement, once per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per 36 months when tooth is present	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Surgical revision procedure, per tooth, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration, once per 36 months when tooth is present	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?
3	Restoration services, limited to:	Cast metal, resin-based or porcelain/ceramic inlay, onlay, and crown for permanent tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Labial veneers	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown, inlay, onlay and veneer repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Simple stress breakers, per unit	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline full or partial denture limited to once per 36 months; denture rebases or relines done within 6 months are considered to be part of the denture placement when the rebase or reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 months after the insertion of the denture.	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns and retainer for fixed partial denture, abutment supported crown and retainer for fixed partial denture, bridges, complete dentures, and/or partial dentures; implant/abutment supported removable denture for completely or partially edentulous arch, implant/abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 months	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	Implants and related services	Surgical placement of implant body, endosteal implant; surgical placement of eposteal or transosteal implant	50%	None	Yes	30%	None	Yes
3	Implants and related services	Radiographs/surgical implant index, limited to once per arch per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Repair implant supported prosthesis, abutment and implant removal	50%	None	Yes	30%	None	Yes
3	Occlusal guards	Limited to one per 12 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion with prior authorization	50%	None	No	30%	None	No

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. 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 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. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (MD) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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	$400	N/A
Two or More Children	$800	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	One (1) topical fluoride application (D1208) is covered two (2) times per calendar year, per patient; four (4) topical fluoride varnish treatments (D1206) are covered per calendar year, per patient for children age three (3) and above; eight (8) topical fluoride varnish treatments (D1206) are covered per calendar year, per patient up to age two (2).	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	Application of 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, D1520 or D1575) 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). Re-cement or re-bond bilateral or unilateral space maintainer (D1551, D1552 or D1553) not covered within 6 months of initial placement. Removal of fixed unilateral and bilateral space maintainer (D1556, D1557 or D1558) not allowed by dental office that provided initial placement.	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

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	Other diagnostic imaging (D0290, D0310, D0320, D0321)		100%	None	No	80%	None	No
1	2D cephalometric radiographic image (D0340) or image capture (D0702)	One per 36 months per patient	100%	None	No	80%	None	No
1	Palliative treatment of dental pain – per visit	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
1	Consultations (D9310)		100%	None	No	80%	None	No
1	House/extended care facility calls		100%	None	No	80%	None	No
1	Application of desensitizing medicament	One per visit. Not to be used for bases, liners or adhesives used under restorations	100%	None	No	80%	None	No
2	Amalgam and resin-based 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
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	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

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	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, one (1) per tooth, impacted teeth only, 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; Surgical repositioning of teeth, one per lifetime per patient per tooth	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, marsupialization of odontogenic 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	Oral surgery, including postoperative care for:	Removal of exostosis (D7471), torus palatinus (D7472), and torus mandibularis (D7473)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Partial ostectomy/ sequestrectomy for removal of non-vital bone	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 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
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy; pulpal debridement; pulpal therapy; pulpal regeneration; 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:	Surgical repair of root resorption (D3471, D3472 and D3473) and surgical exposure of root surfaces without apicoectomy or repair of root resorption (D3501, D3502 and D3503)	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

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:	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:	Gingival flap procedure, including root planing (D4240 and D4241), 1-3 or 4+ contiguous teeth or tooth-bounded spaces,one 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:	Splint-intracoronal; natural teeth or prosthetic crowns (D4322); Splint-extra-coronal; natural teeth or prosthetic crowns (D4323)	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 to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one 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, titanium 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; replacement of inlays, onlays and crowns limited to one per 60 months from the original date of placement, per permanent tooth, per patient; pre-fabricated crowns are limited to one per 36 months per permanent tooth (D2928, D2929), per primary tooth (D2930, D2934) and per primary or permanent tooth (D2932, D2933)	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	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures 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; Reline of custom sleep apnea appliance (indirect)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Adjust complete or partial denture, not covered within 6 months of initial placement.	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, one (1) D5863, D5864 or D5865 per 60 months, per patient	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; Replacement of lost or broken retainer (D8703 or D8704), one per arch per lifetime, allowed within 24 months of date of debanding	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. 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.
11. Treatment of cleft palate (if not treatable through orthodontics) or neoplasms.
12. 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.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (MI) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	0%	None	0%	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations, examinations or limited problem focused re-evaluations	Limited to two (2) per Calendar Year	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation		100%	None	No	80%	None	No
1	Comprehensive oral evaluation		100%	None	No	80%	None	No
1	Prophylaxis/cleaning	Limited to three (3) per Calendar Year	100%	None	No	80%	None	No
1	Fluoride treatment, topical application		100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one set per Calendar Year	100%	None	No	80%	None	No
1	Intraoral periapical or occlusal images	Not on the same date of service as a panoramic radiograph	100%	None	No	80%	None	No
1	Full mouth, complete series or panoramic radiograph	Limited to one per 60 months	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restorations	Limited to permanent molar 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		80%	None	Yes	60%	None	Yes
2	Pin retention of fillings		80%	None	Yes	60%	None	Yes
2	Protective restoration		80%	None	Yes	60%	None	Yes
2	Consultations	Diagnostic service provided by dentist or physician other than requesting dentist or physician	80%	None	Yes	60%	None	Yes
2	Crown build-up for non-vital teeth		80%	None	Yes	60%	None	Yes
2	Cast and prefabricated post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and peridontally	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	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown		80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment or after-hours office visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide		80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay, onlay, crown		80%	None	Yes	60%	None	Yes
2	Pulp vitality tests		80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Accession of tissue, gross and microscopic examination, preparation and transmission of written report		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; surgical access of an erupted tooth; excision of hyperplastic tissue; biopsy of soft tissue; brush biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy, frenulectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; and retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy limited to primary teeth only	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	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:	Incomplete endodontic therapy, inoperable or fractured tooth	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Hemisection, including any root removal	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Periodontal maintenance	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening, hard tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Apically positioned flap	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, resin-based, porcelain/ceramic, titanium inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Labial veneer	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown and bridge repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of fixed bridges including bridge abutments and pontics; each abutment and pontic makes up a unit in a bridge	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline complete or partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed 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:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes
4	Orthodontia Services:	Not Covered	0%	None	No	0%	None	No

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. 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 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. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontia services are not covered.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (MO) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One per six (6) months	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis/cleaning	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment, topical application	Two per twelve (12) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one 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 per 60 months	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restoration	One per tooth per 36 months (limited to occlusal surfaces of permanent molar 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	Composite resin restorations limited to anterior teeth only; coverage for resins on posterior teeth is limited to the corresponding amalgam benefit	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Per tooth, only in conjunction with a permanent amalgam or composite filling restoration	80%	None	Yes	60%	None	Yes
2	Crown build-up for non-vital teeth and cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	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	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown	Once per tooth, per 60 months; prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration	80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment or after-hours office visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide	Must be administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay or onlay, crown, bridge		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration		80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; excision of hyperplastic tissue, vestibuloplasty	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:	Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy and retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, direct and indirect (includes sedative filling); pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation; hemisection, including any root removal	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:	Pulpal therapy limited to primary teeth only	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Incomplete endodontic therapy, inoperable or fractured tooth	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal maintenance or prophylaxis following surgery per 12 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening - hard tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Subepithelial connective tissue graft procedure	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement, once per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per 36 months when tooth is present	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Surgical revision procedure, per tooth, once per 36 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:	Guided tissue regeneration, once per 36 months when tooth is present	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, resin-based or porcelain/ceramic inlay, onlay, and crown for permanent tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Labial veneers	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown, inlay, onlay and veneer repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Simple stress breakers, per unit	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline full or partial denture limited to once per 36 months; denture rebases or relines done within 6 months are considered to be part of the denture placement when the rebase or reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 months after the insertion of the denture.	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns and retainer for fixed partial denture, abutment supported crown and retainer for fixed partial denture, bridges, complete dentures, and/or partial dentures; implant/ abutment supported removable denture for completely or partially edentulous arch, implant/ abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 months	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	Implants and related services	Surgical placement of implant body, endosteal implant; surgical placement of eposteal or transosteal implant	50%	None	Yes	30%	None	Yes
3	Implants and related services	Radiographs/surgical implant index, limited to once per arch per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Repair implant supported prosthesis, abutment and implant removal	50%	None	Yes	30%	None	Yes
3	Occlusal guards	Limited to one per 12 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion with prior authorization	50%	None	No	30%	None	No

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. 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 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. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (NC) Coverage Schedule, Limitations and Exclusions for Pediatric Services

- Coverage continues through end of the year in which the member turns 19 -

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maxmium deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One evaluation (D0120, D0145, D0150, D0160 or D0180) per six (6) months	100%	None	No	80%	None	No
1	Limited evaluation or re-evaluation, problem focused (D0140 or D0170)	One per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months	100%	None	No	80%	None	No
1	Bitewing x-rays	One 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 per 60 months	100%	None	No	80%	None	No
1	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer (D1510, D1516 or D1517) to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer	100%	None	No	80%	None	No
1	Sealants	One 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; protective restorations when not billed on the same day as a normal restoration	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
2	Crown build-up for non-vital teeth	Once per tooth, per 60 months	80%	None	Yes	60%	None	Yes
2	Post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and peridontally, limited to one per tooth per 60 months	80%	None	Yes	60%	None	Yes
2	Prefabricated porcelain and stainless steel crown	Once per tooth, per 60 months; stainless steel crown under age 15	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	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous and non-intravenous sedation	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 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	Recement cast or prefabricated post and core, inlay, crown		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty; excision of periocoronal gingiva; removal of exostosis; incision and drainage of an abscess or cyst, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, one (1) per lifetime, impacted teeth only	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:	Suture of recent small wounds up to 5 cm	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Bone replacement graft for ridge preservation-per site	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	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 permanent tooth; retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy and pulpal debridement; root amputation per root	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy (D3230 and D3240) limited to once per tooth per lifetime	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:	Pulpal regeneration limited to once per tooth per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal regeneration (D3355, D3356 and D3357) limited to once per tooth per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical exposure of root and surgical repair of root resorption	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal cleanings following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months 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 D1110/ D1120, limited to once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including root planing - 1-3 or 4+ contiguous teeth or tooth-bounded spaces, per quadrant once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per quadrant, per 36 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:	Guided tissue regeneration (natural teeth - resorbable and non-resorbable barriers, per site) and biologic materials to aid in osseous tissue regeneration	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Soft tissue allograft, once per quadrant, per 36 months	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	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; one per 60 months from the original date of placement, per permanent tooth, per patient	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Resin infiltration/smooth surface, limited to one in 36 months	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown, inlay, onlay and veneer repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures; repair and adjustment of dentures; addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after 5 years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	One relining of existing removable dentures; or rebonding or recementing fixed denture; per 36 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); reline of custom sleep apnea appliance (indirect)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline complete or partial denture limited to once per 36 months (only after 6 months from date of initial installation)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Cleaning and inspection of removable dentures, once every 6 months	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	Implants and related services (only if determined to be medically necessary)	Dental implants and related services including implant supported crowns, abutments, bridges, complete dentures, and/or partial dentures. Limited to 1 every 60 months	50%	None	Yes	30%	None	Yes
3	Scaling and debridement in the presence of inflammation or mucositis of a single implant	One (1) per two (2) years, including cleaning of the implant surfaces, without flap entry and closure	50%	None	Yes	30%	None	Yes
3	Occlusal guards	Occlusal guard (hard appliance or soft appliance, full arch; hard appliance, partial arch) limited to 1 in 12 months for patients 13 and older; occlusal guard adjustments limited to 1 every 24 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		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

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

1. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
2. Services which are not medically 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 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 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. Treatment required for conditions resulting from acts of terrorism are not excluded.
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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.*
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics) beyond the extent that an otherwise covered dental service is provided.*
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.

* The plan will cover congenital defects and anomalies, including cleft palate, to the same extent an otherwise covered dental service is provided by the plan.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Pediatric* (NJ) Coverage Schedule, Service Limitations and Exclusions for Pediatric Services

- Coverage continues through end of the year in which the member turns 19 -

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	None

Services in Class 1 - Class 4 are listed on p. 2 - 7 of this document

Annual Deductible	In-Network	Out-of-Network
Single Member	$25	$25
Two or More Members	$50	$50
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. The deductible is combined for all applicable services for each calendar year per Member - maximum $50 for Members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Member	$400	N/A
Two or More Members	$800	N/A

- The annual Out-of-Pocket Maximum applies to all covered services for Necessary and Appropriate Dental Services.

Out-of-Network Allowance	
	Maximum Allowable Charge

1. Unlike Participating Dentists that have agreed to negotiated fees for services, Non-Participating Dentists have no contract with Dominion or Dominion's leased dental networks. As such, Non-Participating Dentists set their own fees and Dominion only reimburses the Member based on the Maximum Allowable Charge, a limitation on the billed charges by a Non-Participating Dentist as determined by the geographic area where the expenses are incurred. This means that if the Non-Participating Dentist's fee is higher than Dominion's Maximum Allowable Charge, the Member will be billed the remaining balance to cover the Non-Participating Dentist's fee.

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

Plan will pay either the Participating Dentist's In-Network Allowed Amount or the Out-of-Network Maximum Allowable Charge (subject to service coverage percentage) for dental procedures and services as shown below, after any required annual deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two evaluations (D0120, D0145, D0150, D0160 or D0180) per twelve (12) months	100%	None	No	80%	None	No
1	Limited evaluation or re-evaluation, problem focused	One (D0140, D0170 or D0171) per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months	100%	None	No	80%	None	No
1	Bitewing x-rays		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 (D0210 or D0330)	One every three (3) years	100%	None	No	80%	None	No
1	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Intraoral, extraoral and other radiographic or photographic images (D0240, D0250, D0251, D0340, D0350)		100%	None	No	80%	None	No
1	Space maintainers	Fixed and removable space maintainer (D1510, D1516, D1517, D1520, D1526 and D1527) per arch to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer (cannot be billed by the provider or practice that placed the appliance)	100%	None	No	80%	None	No
1	Sealants	One per tooth, per 60 months (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	100%	None	No	80%	None	No
1	Professional visits/calls for observations, consultations & behavior mgmt - office, house, hospital or other inpatient/ outpatient facility		100%	None	No	80%	None	No
1	Cone beam images; Maxillofacial images, ultrasounds and MRIs		100%	None	No	80%	None	No
1	Diagnostic tests and examinations, including collection, preparation, accession, processing and analysis of viral cultures, samples and smears		100%	None	No	80%	None	No
1	Caries risk assessment and documentation		100%	None	No	80%	None	No
1	Diagnostic imaging with interpretation		100%	None	No	80%	None	No

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	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	80%	None	No
2	Amalgam and composite fillings; gold foil; protective restorations when not billed on the same day as a normal restoration	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations	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
2	Crown build-up	Coverage for non-vital teeth	80%	None	Yes	60%	None	Yes
2	Post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	80%	None	Yes	60%	None	Yes
2	Prefabricated crowns; temporary crowns for a fractured tooth		80%	None	Yes	60%	None	Yes
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service. Out-of-network emergency palliative treatment is covered at the same cost share as if the Member visited a Participating Dentist	80%	None	Yes	80%	None	Yes
2	General anesthesia and analgesic, including intravenous and nonintravenous sedation	Maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure code 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 or D9230; analgesia (nitrous oxide) is not covered with procedure code D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	80%	None	Yes	60%	None	Yes
2	Athletic mouthguard; occlusal guard	Including limited and complete adjustments	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay, crown		80%	None	Yes	60%	None	Yes
2	Administration/application of therapeutic parenteral drug, other drugs and/or medicaments administration	Note medication on claim	80%	None	Yes	60%	None	Yes
2	Other oral pathology procedures, by report		80%	None	Yes	60%	None	Yes
2	Coping		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth except the surgical removal of 3rd molars	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root or partial tooth	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	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:	Incision and drainage of an abscess or cyst, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Mobilization of erupted or malpositioned tooth, covered for all teeth except 3rd molars	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Placement of device to facilitate eruption of impacted tooth (indicate if orthodontia related)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Exfoliative cytological sample collection	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Radical resection of maxilla or mandible	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Other oral surgery procedures and related services	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; retreatment of previous root canal therapy; treatment for root canal obstruction, incomplete therapy and internal root repair of perforation, not within 24 months when done by same Participating Dentist or dental office	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy and pulpal debridement; pulpal therapy and regeneration	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification (endodontists only); apicoectomy; periradicular surgery; root amputation; hemisection	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical procedure for isolation of tooth with rubber dam	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Canal prep and fitting of preformed dowel or post	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Two periodontal cleanings following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One (1) scaling and root planing per quadrant, per six (6) 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:	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/ D1110	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including root planing - 1-3 or 4+ contiguous teeth or tooth-bounded spaces, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle, free soft tissue, subepithelial connective tissue, combined connective tissue or double pedicle graft per site	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration (natural teeth - resorbable and non-resorbable barriers, per site) and biologic materials to aid in osseous tissue regeneration	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Distal or proximal wedge procedure	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Soft tissue allograft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Apically positioned flap	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Biologic materials to aid soft and osseous tissue regeneration	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Surgical revision	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel,porcelain/ceramic, all ceramic and resin-based composite crown; inlay/onlay restorations for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; crown repair; study model (diagnostic cast); post removal	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:	Pediatric partial denture including removable unilateral partial dentures/dentures	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:	Repair of dentures; replacement of dentures that cannot be repaired; addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	One relining or rebasing of existing removable dentures; or rebonding or recementing fixed denture; per 12 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); reline of custom sleep apnea appliance (indirect)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Obturator prosthesis and modification, mandibular resection prosthesis or trismus appliance	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Fluoride and/or topical medication carrier for patients undergoing radiation treatment; radiation carrier, shield and cone locator	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Precision attachment	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Palatal Prosthesis (palatal augmentation, palatal lift prosthesis - definitive, interim and modification)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Commissure and surgical splints and stents	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Other maxillofacial prosthetics including adjustments and appliance removal	50%	None	Yes	30%	None	Yes
3	Implants and related services		50%	None	Yes	30%	None	Yes
3	Odontoplasty		50%	None	Yes	30%	None	Yes
3	Internal bleaching		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?
4	Orthodontia Services:	Orthodontic treatment requires pre-authorization and is not considered for cosmetic purposes. Orthodontic consultation can be provided once annually as needed by the same provider. Preorthodontic treatment visit for completion of the HLD (NJMod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services. Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or Participating Dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service. Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday. Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment. The placement of the appliance represents the treatment start date. Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires preauthorization. Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility. will become the patient's responsibility.	50%	None	No	0%	N/A	N/A

Plan Exclusions

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not Necessary and Appropriate Dental Services 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. 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.
5. 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.
6. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
7. 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 Necessary and Appropriate Dental Services.
8. 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.
9. Treatment of cleft palate, malignancies or neoplasms, except in the case of newborn children or the Necessary Care and Treatment of medically diagnosed congenital defects and birth abnormalities.
10. Orthodontics is only covered as a Necessary and Appropriate Dental Service as determined by the Plan. The Invisalign system and similar specialized braces are not a covered service.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (OH) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One evaluation per six (6) months	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis/cleaning	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment, topical application	Two per twelve (12) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one 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 complete series or panoramic radiographic image	One per 60 months	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restoration	One per tooth per 36 months (limited to occlusal surfaces of permanent molar 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	Composite resin restorations limited to anterior teeth only; Coverage for resins on posterior teeth is limited to the corresponding amalgam benefit	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material	80%	None	Yes	60%	None	Yes
2	Crown build-up for non-vital teeth and cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	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	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown	Once per tooth, per 60 months; prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration	80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide	Covered in conjunction with covered oral surgery, periodontal surgery, or implant placement services	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay or onlay, crown, bridge		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration		80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; excision of hyperplastic tissue, vestibuloplasty	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:	Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy and retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, direct and indirect (includes sedative filling); pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation; hemisection, including any root removal	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:	Pulpal therapy limited to primary teeth only	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical exposure of root and surgical repair of root resorption	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal maintenance or prophylaxis following surgery per 12 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening - hard tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle or free soft tissue grafts	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Subepithelial connective tissue graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration once per 36 months	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, resin-based or porcelain/ceramic crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Inlay, onlay and veneer	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	Restoration services, limited to:	Crown, inlay, onlay and veneer repair and recementation	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of removable dentures or fixed bridges; repair and adjustment of dentures; addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Denture rebase or reline, full or partial, limited to once per denture per 36 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns and retainer for fixed partial denture, abutment supported crown and retainer for fixed partial denture, bridges, complete dentures, and/or partial dentures; implant/abutment supported removable denture for completely or partially edentulous arch, implant/abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Surgical placement of implant body, endosteal implant; surgical placement of eposteal or transosteal implant	50%	None	Yes	30%	None	Yes
3	Occlusal guards	Limited to one per 12 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		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?
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion with prior authorization	50%	None	No	30%	None	No

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate, malignancies or neoplasms.
18. Orthodontics is only covered if medically necessary.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (OR)

Coverage Schedule for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	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. The deductible is combined for all applicable services for each calendar year per pediatric member - maximum $100 for pediatric members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$400	N/A
Two or More Children	$800	N/A

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

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, prior review is recommended.

Plan will pay either the participating dentist's negotiated fee or the maximum allowable charge (subject to service coverage percentage) for dental procedures and services as shown below, after any required annual deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two (D0120, D0145, D0150, D0160, or D0180) per twelve (12) months; coverage for all evaluations by medical practitioners who are oral surgeons	100%	None	No	80%	None	No
1	Limited evaluations	Limited evaluation or re-evaluation, problem focused (D0140 or D0170) do not count against annual exam frequency limitation	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months (additional topical fluoride treatments may be available when high risk conditions or oral health factors are present)	100%	None	No	80%	None	No
1	Bitewing x-rays	Four per six (6) months	100%	None	No	80%	None	No
1	Periapical x-rays	Limited to six (6) films per 12 months under age six (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 per 36 months (starting at age six)	100%	None	No	80%	None	No
1	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Space maintainers	Covers fixed and removable space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer (cannot be billed by the provider or practice that placed the appliance)	100%	None	No	80%	None	No
1	Sealants	One per tooth, per 60 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

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	Amalgam and composite fillings	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; includes occlusal adjustment and polishing of restoration; protective restorations when not billed on the same day as a normal restoration	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
2	Crown build-up	Covered for non-vital teeth	80%	None	Yes	60%	None	Yes
2	Post and core	Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	80%	None	Yes	60%	None	Yes
2	Prefabricated crowns	One per tooth per 60 months	80%	None	Yes	60%	None	Yes
2	Temporary crowns	Covered for a fractured tooth	80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment	Emergency palliative treatment; the use of a house/extended care facility call (D9410) is available for urgent or emergent dental visits that occur outside of a dental office	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

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	Occlusal guard	Coverage with covered surgery, by report	80%	None	Yes	60%	None	Yes
2	Re-cement cast or prefabricated post and core, inlay, crown		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth except the surgical removal of third molars; includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction (surgical removal of impacted teeth or removal of residual tooth roots limited to teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	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	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:	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 permanent tooth (not covered for third molars); retreatment of previous root canal therapy, on anterior teeth, one 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:	Pulp cap; pulpotomy and pulpal debridement, pulpal therapy and regeneration; apexification/ recalcification (endodontists only); apicoectomy; retrograde fillings	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One periodontal cleaning following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years, per six months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, once per quadrant, per 24 months	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:	Gingivectomy/ gingivoplasty (D4210/ D4211), limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue or double pedicle 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?
3	Restoration services, limited to:	Cast metal, stainless steel, 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; permanent crown replacement limited to once every seven years and all other crown replacements limited to once every five years; stainless steel crowns (D2930/D2931) allowed only for anterior primary and posterior permanent or primary teeth; prefabricated stainless steel crowns (D2933) allowed only for anterior teeth, permanent and porcelain fused to metal crowns limited to teeth numbers 6-11, 22 and 27 only; members age 16 through 18; includes preparation of gingival tissue	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; members age 16 and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140); includes adjustments during six-month period following delivery	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures	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:	Replacement of removable partial or full dentures that cannot be repaired for members at least 16 and under 19; shall replace full every 10 years or partial dentures once every 5 years from the date of last placement; interim partial dentures or flippers (D5820-D5821) covered if the member has one or more anterior teeth missing and are covered once per five years when dentally appropriate	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
3	Prosthetic services, limited to:	One relining or rebasing of existing removable dentures; or rebonding or recementing fixed denture; per 36 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); laboratory relines are not covered prior to six months after placement of an immediate denture and are limited to once per 36 months; rebases covered only if a reline may not adequately solve the problem; exceptions to this limitation may be made in the event of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This includes, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for these conditions (severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing)	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:	Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Fluoride gel carrier for patients with severe oral disease	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning (not covered when performed within 6 months of any denture)	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		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 or members with the ICD-10-CM diagnosis of cleft palate or cleft palate with cleft lip.	50%	None	No	0%	None	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, with the exception of dental emergencies.
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 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.

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (PA) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	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. The deductible is combined for all applicable services for each calendar year per pediatric member - maximum $100 for pediatric members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$400	N/A
Two or More Children	$800	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, 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	Application of 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	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one (1) pin	80%	None	Yes	60%	None	Yes
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	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	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	80%	None	Yes	60%	None	Yes
2	Occlusal guard	Analysis and limited/ complete adjustment, one (1) in 12 months for patients 13 and older, by report	80%	None	Yes	60%	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	80%	None	Yes	60%	None	Yes
2	Addition of teeth to existing partial denture		80%	None	Yes	60%	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	80%	None	Yes	60%	None	Yes
2	Repair of crowns, dentures and bridges		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, impacted teeth only, one per lifetime	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, and frenectomy	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	Oral surgery, including postoperative care for:	Excision of periocoronal gingiva, exostosis or hyper plastic 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 tumor or cyst and incision and drainage of an abscess or cyst, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy; apicoectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, one (1) per root per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Two (2) periodontal cleanings, in addition to adult prophylaxis, per calendar year, within 24 months after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, one (1) per 24 months, per quadrant, per patient	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 D1110/ D1120, limited to one (1) per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, one (1) per 36 months per patient, per quadrant; gingival irrigation with a medicinal agent, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, one (1) per 36 months per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle or free soft tissue graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one (1) per lifetime	80%	None	Yes	60%	None	Yes
3	Study model	One (1) per 36 months	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	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	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; protective restoration; post removal; crown buildup for non-vital teeth	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:	Replacement of dentures that cannot be repaired after five (5) years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction of bridges, replacement limited to one (1) per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Replacement of implant crowns limited to one (1) in 60 months	50%	None	Yes	30%	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.	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		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	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.

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (VA) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maxmium deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$400	N/A
Two or More Children	$800	N/A

- The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.
- The single child out-of-pocket maxmium amount must be met by one child prior to satisfying the two or more children out-of-pocket maxmium amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One (D0120, D0145 or D0150) per six (6) months, per patient	100%	None	No	80%	None	No
1	Re-evaluation, limited or problem focused	One exam per six (6) months, per patient	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months, per patient	100%	None	No	80%	None	No
1	Fluoride treatments	One per six (6) months, per patient	100%	None	No	80%	None	No
1	Bitewing x-rays		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 x-rays		100%	None	No	80%	None	No
1	Application of 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 (unilateral) or per arch (bilateral), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer (cannot be billed by the provider or practice that placed the appliance); 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	Diagnostic cast	Only if not in conjunction with orthodontic treatment	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 12 months	80%	None	Yes	60%	None	Yes
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	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	Local anesthesia; general anesthesia and analgesic, including intravenous and non-intravenous sedation	Maximum of 150 minutes or 10 units of general anesthesia and sedation allowed; requires a narrative of medical necessity be maintained in patient records. The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment	80%	None	Yes	60%	None	Yes
2	Hospital call	Facility and anesthesia charges are considered medical services; 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	For grinding and clenching of teeth, by report	80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim; desensitizing medicaments	80%	None	Yes	60%	None	Yes
2	Consultations	When not performed by another dentist within the same facility and not in conjunction with orthodontia	80%	None	Yes	60%	None	Yes
2	Prefabricated crowns	Once per tooth, per 36 months	80%	None	Yes	60%	None	Yes
2	Temporary crowns	Coverage only for a fractured tooth	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
2	Crown build-up	Coverage for non-vital teeth	80%	None	Yes	60%	None	Yes
2	Post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core; recement crown		80%	None	Yes	60%	None	Yes
2	Protective restoration		80%	None	Yes	60%	None	Yes
2	Labial veneer	One (1) per 60 months, per tooth (will be considered as an alternative to a full restoration for an endodontically treated tooth)	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, impacted teeth only, one (1) per lifetime	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	Oral surgery, including postoperative care for:	One (1) alveoloplasty per quadrant per patient per lifetime; one (1) frenulectomy or frenuloplasty per patient per lifetime	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, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of oral tissue, odontogenic cyst, torus palatinus and mandibularis (D7285, D7286)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Oroantral fistula closure and primary closure of a sinus perforation	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Occlusal orthotic device for TMJ (D7880)	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 permanent tooth, per lifetime, per patient; retreatment of previous root canal therapy, once per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy and pulp cap; pulpal therapy and pulpal debridement; pulpal regeneration	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification limited to one (1) per tooth per provider, per lifetime; D3352 limited to three (3) treatments per tooth, per provider, per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Periradicular surgery without apicoectomy, one per tooth, per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apicoectomy, one (1) per tooth, per patient, per lifetime	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:	Four periodontal cleanings following surgery per 12 months after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One (1) scaling and root planing, per 24 months, per quadrant, per patient	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:	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 performed with covered surgery	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months, per quadrant, per patient and gingival irrigation with a medicinal agent, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 60 months, per quadrant, per patient	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle, subepithelial, bone replacement or free soft tissue graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit, one (1) per 12 months, only covered when there is substantial gingival inflammation in all four (4) quadrants	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal crown, porcelain/ ceramic crown, porcelain/ ceramic onlay, all ceramic crown and resin-based composite onlay (D2644), only 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	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete or partial dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Immediate denture, one per arch per lifetime per patient	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures; rebonding or recementing fixed denture; denture adjustment	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of complete or partial dentures that cannot be repaired after five (5) 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:	One (1) relining or rebasing of existing removable dentures per tooth per 24 months (only after six (6) months from date of last placement)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Feeding aid (D5951)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recement fixed partials as needed	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Pontics and retainers, one per 60 months per patient per tooth	50%	None	Yes	30%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable and fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting), replacement of lost or broken retainer (D8692), and comprehensive therapy; Orthodontia services limited to once per lifetime and are only provided for severe, dysfunctional, handicapping malocclusion.	50%	None	No	0%	None	No

Plan Exclusions

Please refer to the section in your Individual Dental Policy titled "State-Specific Exclusions or Exceptions" for additional exclusions and/or exceptions to the following exclusions, if applicable.

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. 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) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires medically necessary orthodontia services or an occlusal orthotic device, by report, for temporomandibular pain, dysfunction or associated musculature.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth. 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.
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 (if not treatable through orthodontics), malignancies or neoplasms.
17. Orthodontics is only covered if medically necessary. 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, including pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, one set of retainers and 12 months of retainer adjustments. Additional costs incurred will become the patient's responsibility.

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

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (WI) Coverage Schedule, Limitations and Exclusions for Pediatric Services

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

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	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 combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

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

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One per six (6) months	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation	One per six (6) months	100%	None	No	80%	None	No
1	Prophylaxis/cleaning	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment, topical application	Two per twelve (12) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one 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 per 60 months	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restoration	One per tooth per 36 months (limited to occlusal surfaces of permanent molar 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	Composite resin restorations limited to anterior teeth only; coverage for resins on posterior teeth is limited to the corresponding amalgam benefit	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Per tooth, only in conjunction with a permanent amalgam or composite filling restoration	80%	None	Yes	60%	None	Yes
2	Crown build-up for non-vital teeth and cast and prefabricated post and core	Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure	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	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown	Once per tooth, per 60 months; prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration	80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment or after-hours office visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide	Must be administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay or onlay, crown, bridge		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration		80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; excision of hyperplastic tissue, vestibuloplasty	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:	Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy and retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, direct and indirect (includes sedative filling); pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation; hemisection, including any root removal	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:	Pulpal therapy limited to primary teeth only	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Incomplete endodontic therapy, inoperable or fractured tooth	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal maintenance or prophylaxis following surgery per 12 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure and scaling and root planing, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening - hard tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Subepithelial connective tissue graft procedure	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement, once per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per 36 months when tooth is present	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Distal or proximal wedge procedure, not in conjunction with osseous surgery, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Surgical revision procedure, per tooth, once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration, once per 36 months when tooth is present	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?
3	Restoration services, limited to:	Cast metal, resin-based or porcelain/ceramic inlay, onlay, and crown for permanent tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Labial veneers	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown, inlay, onlay and veneer repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Simple stress breakers, per unit	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline full or partial denture limited to once per 36 months; denture rebases or relines done within 6 months are considered to be part of the denture placement when the rebase or reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 months after the insertion of the denture.	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges; replacement of a bridge that cannot be repaired, limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Implants and related services	Dental implants and related services including implant supported crowns and retainer for fixed partial denture, abutment supported crown and retainer for fixed partial denture, bridges, complete dentures, and/or partial dentures; implant/abutment supported removable denture for completely or partially edentulous arch, implant/abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 months	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	Implants and related services	Surgical placement of implant body, endosteal implant; surgical placement of eposteal or transosteal implant	50%	None	Yes	30%	None	Yes
3	Implants and related services	Radiographs/surgical implant index, limited to once per arch per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Repair implant supported prosthesis, abutment and implant removal	50%	None	Yes	30%	None	Yes
3	Occlusal guards	Limited to one per 12 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion with prior authorization	50%	None	No	30%	None	No

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. 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 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. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.