DOMINION NATIONAL DENTAL

Underwritten by: Dominion Dental Services, Inc. d/b/a Dominion National

Elite PPO Premium *Kids* (VA)

Coverage Schedule for Pediatric Services

- under age 19 (coverage continues through end of month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	80%
Class II	80%	60%
Class III	50%	30%
Class IV	50%	0%
Endo/Perio	Class II Benefits	Class II Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Child	$50	$50
Two or More Children	$100	$100
Applies to all Benefits	*No, Waived on Class I and IV Benefits*	*No, Waived on Class I Benefits*
Out-of-Pocket Maximums	**In-Network**	**Out-of-Network**
Single Child	$350	N/A
Two or More Children	$700	N/A
* Annual Out-of-Pocket Maximum applies to all covered services for medically necessary treatment.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods: None		

- Deductible is combined for all covered services for each calendar year per pediatric Member – maximum $100 for pediatric Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, pre-authorization is required.
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

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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.

Class I. Diagnostic and Preventive Services:

1. One (1) evaluation (D0120, D0145 or D0150) per six (6) months, per patient
2. One (1) re-evaluation limited or problem focused exam per six (6) months, per patient
3. One (1) prophylaxis (D1110 or D1120) per six (6) months, per patient
4. One (1) fluoride treatment is covered per six (6) months, per patient
5. Bitewing x-rays
6. Periapical x-rays (not on the same date of service as a panoramic radiograph)
7. Full mouth or panoramic x-rays
8. One (1) space maintainer 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)
9. One (1) sealant per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)
10. Diagnostic cast only if not in conjunction with orthodontic treatment

Class II. Basic Services:

1. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 12 months
2. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
3. Local anesthesia; general anesthesia and analgesic, including intravenous and non-intravenous sedation with a maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure codes D9230 or D9243; intravenous conscious sedation is not covered with procedure codes D9223 or D9230; non-intravenous conscious sedation is not covered with procedure codes D9223 or D9230; analgesia (nitrous oxide) is not covered with procedure codes D9223 or D9243); requires a narrative of medical necessity be maintained in patient records
4. 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
5. Occlusal guard, by report (for grinding and clenching of teeth)
6. Therapeutic parenteral drug administration (note medication on claim), desensitizing medicaments
7. Consultations when not performed by another dentist within the same facility and not in conjunction with orthodontia
8. Prefabricated crowns, once per tooth, per 36 months
9. Temporary crowns for a fractured tooth
10. Pin retention of fillings (multiple pins on the same tooth are allowable as one (1) pin)
11. Crown build-up for non-vital teeth.
12. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
13. Recement cast or prefabricated post and core; recement crown
14. Protective restoration
15. Labial veneer per 60 months, one (1) per tooth (will be considered as an alternative to a full restoration for an endodontically treated tooth)
16. Oral surgery, including postoperative care for:
    a. Removal of teeth, including impacted teeth
    b. Extraction of tooth root or partial tooth
    c. Alveoplasty, frenectomy and frenuloplasty
    d. Excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy
    e. Tooth reimplantation and/or stabilization; tooth transplantation
    f. Excision of a lesion, tumor or cyst and incision and drainage of an abscess or cyst
    g. Removal of oral tissue, odontogenic cyst, torus palatinus and mandibularis (D7285, D7286)
    h. Oroantral fistula closure and primary closure of a sinus perforation
    i. Biopsy
    j. Occlusal orthotic device for TMJ (D7880)
17. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
    a. Root canal therapy, once per permanent tooth, per lifetime, per patient; retreatment of previous root canal therapy, once per lifetime, not within 24 months when done by same dentist or dental office
    b. Pulpotomy and pulp cap
    c. Pulpal therapy and pulpal debridement
    d. Pulpal regeneration
    e. Apexification/recalcification (D3351, D3352) limited to three (3) treatments; D3353 limited to one (1) per tooth, per patient, per lifetime
    f. Periradicular surgery without apicoectomy, one per tooth, per lifetime
    g. Apicoectomy, one (1) per tooth, per patient, per lifetime
    h. Retrograde fillings, per root, per lifetime
18. Periodontic services, limited to:
    a. Four (4) periodontal cleanings following surgery (D4341 is not considered surgery) per 12 months after definitive periodontal therapy
    b. One (1) root scaling and planing per 24 months, per quadrant, per patient
    c. Occlusal adjustment performed with covered surgery
    d. Gingivectomy or gingivoplasty, once per 24 months, per quadrant, per patient
    e. Osseous surgery including flap entry and closure, once per 24 months, per quadrant, per patient
    f. Provisional splinting
    g. Pedicle, subepithelial, bone replacement or free soft tissue graft
    h. One (1) full mouth debridement per 12 months, only covered when there is substantial gingival inflammation in all four (4) quadrants

Class III. Major Services:

1. Restoration services, limited to:
    a. Cast metal crown, porcelain/ceramic crown, 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
2. Prosthetic services, limited to:
    a. Initial placement of dentures
    b. Repair of dentures; rebonding or recementing fixed denture
    c. Denture adjustment
    d. Replacement of dentures that cannot be repaired after five (5) years from the date of last placement
    e. Addition of teeth or clasp to existing partial denture
    f. One (1) relining or rebasing of existing removable dentures per 24 months (only after six (6) months from date of last placement)
    g. Feeding aid (D5951)
    h. Construction and repair of bridges (replacement of a bridge that cannot be repaired limited to once in 60 months)
    i. Tissue conditioning
    j. Recement fixed partials as needed

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Class IV. *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 are only provided for severe, dysfunctional, handicapping malocclusion.

Plan Exclusions

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. 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.

DOMINION NATIONAL
DENTAL

Elite PPO Premium *Kids* (MD)

Coverage Schedule for Pediatric Services

- under age 19 (coverage continues through end of month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	80%
Class II	80%	60%
Class III	50%	30%
Class IV	50%	30%
Endo/Perio	Class II Benefits	Class II Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Child	$50	$50
Two or More Children	$100	$100
Applies to all Benefits	*No, Waived on Class I and IV Benefits*	*No, Waived on Class I and IV Benefits*
Out-of-Pocket Maximums	**In-Network**	**Out-of-Network**
Single Child	$350	N/A
Two or More Children	$700	N/A
* Annual Out-of-Pocket Maximum applies to all covered services for medically necessary treatment.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods: There are no waiting periods with the exception of medically necessary orthodontia, which requires a 24-month waiting period.		

- There is a $50 deductible per pediatric Member per Calendar Year. 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.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, pre-authorization is required.
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

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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.

Class I. Diagnostic and Preventive Services:

1. Two evaluations (D0120, D0145, D0150 or D0160) per calendar year, per patient per provider/location
2. One re-evaluation limited, problem focused or periodontal exam (D0170 or D0180) per calendar year; limited oral evaluation (D0140)
3. Two prophylaxis (D1110 or D1120) per calendar year, per patient
4. Four fluoride treatments are covered per calendar year, per patient, (ages 0-2 eight fluoride varnishes per calendar year, per patient) including topical application of fluoride
5. Bitewing x-rays, two per plan year, starting at age two, per provider/location (D0270 does not have a frequency limitation)
6. Periapical x-rays
7. One full mouth x-ray or panoramic film (starting at age six) per 36 months; maximum of one set of x-rays per provider/location
8. One space maintainer per 24 months, per quadrant (D1510 or D1520) or per arch (D1515 or D1525), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)
9. One sealant per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)
10. Other diagnostic imaging (D0290, D0310, D0320, D0321)
11. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
12. Pulp vitality tests

Class II. Basic Services:

1. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 36 months
2. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
3. 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
4. Occlusal guard with covered surgery, by report, per 24 months
5. General anesthesia and analgesic, including intravenous and non-intravenous sedation with a maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure codes D9230 orD9243; intravenous conscious sedation is not covered with procedure codes D9223 or D9230; non-intravenous conscious sedation is not covered with procedure codes D9223 or D9230; analgesia (nitrous oxide) is not covered with procedure codes D9223 or D9243); requires a narrative of medical necessity be maintained in patient records
6. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root or partial tooth
   c. Alveolectomy, alveoplasty, frenectomy and vestibuloplasty
   d. Excision of periocoronal gingiva, exostosis or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a benign lesion, tumor or cyst and incision and drainage of an abscess or cyst
   g. Biopsy of oral tissue (D7285, D7286)
   h. Hemisection
7. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
   a. Root canal therapy; once per lifetime, per patient, per permanent tooth; Retreatment of previous root canal therapy, one per tooth, per lifetime, not within 24 months when done by same dentist or dental office
   b. Pulpotomy
   c. Pulpal therapy
   d. Apexification/recalcification
   e. Apicoectomy
   f. Retrograde fillings, per root per lifetime
   g. Root amputation (resection)
   h. Pulp caps
8. Periodontic services, limited to:
   a. Two periodontal cleanings following surgery (D4341 is not considered surgery) per plan year after definitive periodontal therapy
   b. One root scaling and planing, once per 24 months, per patient, per quadrant
   c. Occlusal adjustment performed with covered surgery
   d. Gingivectomy or gingivoplasty, once per 24 months, per patient, per quadrant
   e. Anatomical crown exposure and clinical lengthening
   f. Osseous surgery including flap entry and closure, once per 24 months, per patient, per quadrant
   g. Provisional splinting
   h. One pedicle or free soft tissue graft per site, per lifetime
   i. One full mouth debridement per 24 months
   j. Localized delivery of chemotherapeutic 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)
   k. Periodontal maintenance limited to twice per 12 months after definitive periodontal therapy

Class III. Major Services:

1. One study model per 36 months
2. Restoration services, limited to:
   a. Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite inlay, onlay, or crown for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling one per 60 months from the original date of placement, per permanent tooth, per patient (D2930, D2932, D2933, D2934 one per 36 months from the original date of placement, per primary tooth, per patient)
   b. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
   c. Protective restoration
   d. Post removal
   e. Crown build-up for non-vital teeth
   f. Labial veneer per 60 months, per arch
   g. Re-cement crowns/inlays
3. Prosthetic services, limited to:
   a. Initial placement of dentures
   b. Repair of dentures twice per year and five total per five years
   c. Replacement of dentures that cannot be repaired after five years from the date of last placement
   d. Addition of teeth or clasp to existing partial denture
   e. Relining or rebasing of existing removable dentures; rebonding or recementing fixed denture
   f. Adjustment and maintenance of maxillofacial prosthetics, limited to D5992 and D5993, one each per patient, per six months, per arch
   g. Overdenture per 60 months, per arch
   h. Tissue conditioning
   i. Fabrication of athletic mouthguard

Class IV. *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. A 24-month waiting period applies to medically necessary orthodontia.

Plan Exclusions

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 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 with the exception of a retainer.
10. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth. The prophylactic removal of these teeth may be covered subject to review.
11. 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.
12. Services not listed as covered.
13. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function. Bridges are not covered.
14. 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.
15. Treatment of cleft palate (if not treatable through orthodontics) or neoplasms.
16. Orthodontics is only covered if medically necessary as determined by the Plan. There is a 24-month waiting period for Medically Necessary Orthodontia. 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.