DOMINION® NATIONAL
DENTAL

Elite PPO Plus (DC)
Coverage Schedule for Adult Services

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	Class III & II/III Benefits	Class III & II/III Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Benefits	*Yes*	*Yes*
Maximums	**In-Network**	**Out-of-Network**
Annual	$750	$750
* Annual Maximum applies to Class I, Class II and Class III Benefits.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar year per adult Member – maximum $150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- 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.

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National.

Dominion National
251 18th Street South; Suite 900
Arlington, VA 22202
888.518.5338
DominionNational.com

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 per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. One appliance (night guards) per 5 years (within 6 months of osseous surgery)
   e. One full mouth debridement per lifetime
   f. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Tooth re-implantation and/or stabilization; tooth transplantation
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
   g. Coronectomy, intentional partial tooth removal, one (1) per lifetime
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years
11. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
12. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:

1. Services which are covered under worker's compensation, employer's liability laws or the Pennsylvania Motor Vehicle Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

DOMINION® NATIONAL
DENTAL

Elite PPO Plus (DE)
Coverage Schedule for Adult Services

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	Class III & II/III Benefits	Class III & II/III Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Benefits	*Yes*	*Yes*
Maximums	**In-Network**	**Out-of-Network**
Annual	$750	$750
* Annual Maximum applies to Class I, Class II and Class III Benefits.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar year per adult Member – maximum $150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- 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.

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National.

Dominion National
251 18th Street South; Suite 900
Arlington, VA 22202
888.518.5338
DominionNational.com

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 per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. One appliance (night guards) per 5 years (within 6 months of osseous surgery)
   e. One full mouth debridement per lifetime
   f. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Tooth re-implantation and/or stabilization; tooth transplantation
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
   g. Coronectomy, intentional partial tooth removal, one (1) per lifetime
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years
11. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
12. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:

1. Services which are covered under worker's compensation, employer's liability laws or the Pennsylvania Motor Vehicle Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

DOMINION® NATIONAL DENTAL

Choice PPO Plus (GA)
Coverage Schedule for Adult Services

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	100%
Class II	50%	50%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	Class III & II/III Benefits	Class III & II/III Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Benefits	*Yes*	*Yes*
Maximums	**In-Network**	**Out-of-Network**
Annual	$750	$750
* Annual Maximum applies to Class I, Class II and Class III Benefits.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar year per adult Member – maximum $150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- 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.

Dominion National Insurance Company
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Arlington, VA 22202
888.518.5338
DominionNational.com

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 per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years
   d. Occlusal adjustment performed with covered surgery
   e. One appliance (night guards) per 5 years (within 6 months of osseous surgery)
   f. One full mouth debridement per lifetime

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
   d. Alveolectomy, alveoplasty, and frenectomy
   e. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   f. Tooth re-implantation and/or stabilization; tooth transplantation
   g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years.
11. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
12. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

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. 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.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

DOMINION® NATIONAL DENTAL

Elite PPO Plus (MD)
Coverage Schedule for Adult Services

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	Class III & II/III Benefits	Class III & II/III Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Benefits	*Yes*	*Yes*
Maximums	**In-Network**	**Out-of-Network**
Annual	$750	$750
* Annual Maximum applies to Class I, Class II and Class III Benefits.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- There is a $50 deductible per adult Member per Calendar Year. For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- 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.

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National.

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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 per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year - no waiting periods
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays - no waiting periods
7. One full mouth or panoramic x-ray per 60 months - no waiting periods

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. One appliance (night guards) per 5 years (within 6 months of osseous surgery
   e. One full mouth debridement per lifetime
   f. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Tooth re-implantation and/or stabilization; tooth transplantation
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
   g. Coronectomy, intentional partial tooth removal, one (1) per lifetime
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, porcelain/ceramic, all ceramic and resin-based inlays, onlays, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years
11. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
12. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

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. 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.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.
18. 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.

DOMINION® NATIONAL DENTAL

Dominion National Insurance Company

Choice PPO Plus (NJ)
Coverage Schedule, Exclusions and Limitations

- age 19 and over -

Service Coverage	In-Network	Out-of-Network
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endodontics/Periodontics/ Oral Surgery	Class III & II/III Services	Class III & II/III Services
Services in Class I - Class IV are listed on the back of this document.		
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Services	*Yes*	*Yes*
Annual Maximums	**In-Network**	**Out-of-Network**
	$750	$750
* Annual Maximum applies to Class I, Class II and Class III Services.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar year per adult Member – maximum $150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested. This is not mandatory but would allow the member to see the cost of treatment prior to services.
- 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.

Dominion National Insurance Company
251 18th Street South; Suite 900
Arlington, VA 22202
888.518.5338
DominionNational.com

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.

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service). Out-of-network emergency pallative treatment is covered at the same cost share as if the member visited a Participating Plan Dentist
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. One appliance (night guards) per five years (within 6 months of osseous surgery
   e. One full mouth debridement per lifetime

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Tooth re-implantation and/or stabilization; tooth transplantation
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
   g. Coronectomy - intentional partial tooth removal, once per lifetime
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
   d. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
    e. 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 once per two years
11. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

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. 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 as determined by the Plan.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

DOMINION® NATIONAL
DENTAL

Choice PPO Plus (OR)
Coverage Schedule for Adult Services

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

Benefit Coverage	In-Network	Out-of Network
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	Class III & II/III Benefits	Class III & II/III Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Benefits	Yes	Yes
Maximums	**In-Network**	**Out-of-Network**
Annual	$750	$750
Lifetime Ortho Maximum	N/A	N/A
* Annual Maximum applies to Class I, Class II and Class III Benefits.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- Deductible is combined for all services for each calendar year per adult Member - maximum $150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- 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.

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National.

DMNOR19SOBINDFAMEHB

Dominion National
251 18th Street South; Suite 900
Arlington, VA 22202
888.518.5338
DominionNational.com
PID 3583

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 per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   g. One appliance (night guards) per 5 years (within 6 months of osseous surgery)
   h. One full mouth debridement per lifetime
   i. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Tooth re-implantation and/or stabilization; tooth transplantation
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
   g. Coronectomy, intentional partial tooth removal, one (1) per lifetime
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings,per root perlifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years
11. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement

c. Addition of teeth to existing partial denture
d. One relining or rebasing of existing removable dentures per 24 months

12. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

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. 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.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

DOMINION® NATIONAL DENTAL

Elite PPO Plus (PA)
Coverage Schedule for Adult Services

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	Class III & II/III Benefits	Class III & II/III Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Benefits	*Yes*	*Yes*
Maximums	**In-Network**	**Out-of-Network**
Annual	$750	$750
* Annual Maximum applies to Class I, Class II and Class III Benefits.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar year per adult Member – maximum $150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- 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.

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National.

Dominion National
251 18th Street South; Suite 900
Arlington, VA 22202
888.518.5338
DominionNational.com

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 per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. One appliance (night guards) per 5 years (within 6 months of osseous surgery)
   e. One full mouth debridement per lifetime
   f. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Tooth re-implantation and/or stabilization; tooth transplantation
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
   g. Coronectomy, intentional partial tooth removal, one (1) per lifetime
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years
11. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
12. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:

1. Services which are covered under worker's compensation, employer's liability laws or the Pennsylvania Motor Vehicle Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

DOMINION® NATIONAL DENTAL

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

Elite PPO Plus (VA)
Coverage Schedule for Adult Services

- age 19 and over (coverage begins the first day of the month following the month in which the Member turns 19) -

Benefit Coverage	**In-Network**	**Out-of Network**
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	Class III & II/III Benefits	Class III & II/III Benefits
Annual Deductible	**In-Network**	**Out-of-Network**
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to all Benefits	*Yes*	*Yes*
Maximums	**In-Network**	**Out-of-Network**
Annual	$750	$750
* Annual Maximum applies to Class I, Class II and Class III Benefits.		
	In-Network	**Out-of-Network**
Out-of-Network Allowance	N/A	MAC
Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
Class IV	N/A	N/A

- Deductible is combined in and out-of-network for all services for each Calendar year per adult Member – maximum $150 for adult Members.
- The single adult deductible amount must be met prior to satisfying the three or more adults deductible amount.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.
- 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.

Dominion National
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888.518.5338
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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 per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year
5. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. One appliance (night guards) per 5 years (within 6 months of osseous surgery)
   e. One full mouth debridement per lifetime
   f. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
   d. Alveolectomy, alveoplasty, and frenectomy
   e. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   f. Tooth reimplantation and/or stabilization; tooth transplantation
   g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, one per 60 months from the original date of placement, per permanent tooth, per patient
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years
11. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months
12. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. Orthodontia Services: Not Covered

Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy

Plan Exclusions:

1. Services which are covered under worker's compensation employer's or liability laws.
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.