DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (DC)

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: There are no waiting periods.		

- 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.

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. One evaluation (D0120, D0140, D0150, D0160 or D0180) per six (6) months, per patient. D0150 limited to once per 12 months
2. One prophylaxis (D1110 or D1120) per six (6) months, per patient
3. One (1) fluoride treatment is covered every six (6) months, per patient
4. Bitewing x-rays, one set per six (6) months, starting at age two
5. Periapical x-rays (not on the same date of service as a panoramic radiograph)
6. One full mouth x-ray or panoramic film (starting at age six) per 60 months; maximum of one set of x-rays per office visit
7. One space maintainer (D1515 or D1525) per 24 months per patient per arch 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
8. One sealant per tooth per 36 months, (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)

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. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
4. 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
5. Occlusal guard, analysis and limited/complete adjustment, one in 12 months for patients 13 and older, by report.
6. Prefabricated stainless steel or porcelain 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
7. Addition of teeth to existing partial denture
8. One relining or rebasing of existing removable dentures per 36 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth)
9. Repair of crowns, dentures and bridges twice per year and five total per 5 years
10. 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
11. 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 lifetime, not within 24 months when done by same dentist or dental office
    b. Pulpotomy
    c. Apicoectomy
    d. Retrograde fillings, per root per lifetime
12. Periodontic services, limited to:
    a. Two periodontal cleanings, in addition to adult Prophylaxis, per plan year, within 24 months after definitive periodontal therapy
    b. One root scaling and planing, once per 24 months per patient, per quadrant
    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 once per two years
    d. Gingivectomy, once per 36 months per patient, per quadrant
    e. Osseous surgery including flap entry and closure, once per 36 months per patient, per quadrant
    f. One pedicle or free soft tissue graft per site per lifetime
    g. One full mouth debridement per lifetime

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 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
    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
3. Prosthetic services, limited to:
    a. Initial placement of dentures
    b. Replacement of dentures that cannot be repaired after 5 years from the date of last placement
    c. Construction of bridges, replacement limited to once per 60 months
    d. Implants and related services. Replacement of implant crowns limited to once in 60 months
4. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

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.

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* (DE)

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: There are no waiting periods.		

- 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.

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. One evaluation (D0120, D0145, D0150 or D0160) per six (6) months
2. One limited evaluation or re-evaluation, problem focused (D0140 or D0170) per 12 months
3. One prophylaxis (D1110 or D1120) per six (6) months
4. One fluoride treatment per six (6) months
5. Four bitewing x-ray films per six (6) months
6. Periapical x-rays (not on the same date of service as a panoramic radiograph)
7. One full mouth x-ray or panoramic film per 36 months
8. One fixed space maintainer (D1510, D1515) 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
9. One sealant per tooth, per 60 months, to age 16 (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)

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 24 months; sedative fillings when not billed on the same day as a normal restoration
2. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
3. Crown build-up for non-vital teeth
4. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
5. Prefabricated crowns, once per tooth, per 60 months
6. Temporary crowns for a fractured tooth
7. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
8. 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, 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
9. Occlusal guard with covered surgery, by report, per 24 months
10. Recement cast or prefabricated post and core, inlay, crown
11. Therapeutic parenteral drug administration (note medication on claim)
12. Oral surgery, including postoperative care for:
    a. Removal of teeth except the surgical removal of 3rd molars.
    b. Extraction of tooth root or partial tooth
    c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
    d. Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty, limited to ages 14-18
    e. Excision of periocoronal gingiva or hyperplastic tissue and excision of oral tissue for biopsy, limited to ages 14-18
    f. Tooth re-implantation and/or stabilization; tooth transplantation
    g. Incision and drainage of an abscess or cyst
    h. Biopsy of oral tissue (D7285, D7286)
    i. Mobilization of erupted or malpositioned tooth, covered for all teeth except 3rd molars
    j. Placement of device to facilitate eruption of impacted tooth (indicate if orthodontia related)
    k. Sutures, limited to ages 14-18
13. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
    a. Root canal therapy; once per lifetime per permanent tooth; retreatment of previous root canal therapy, one per lifetime, not within 24 months when done by same dentist or dental office
    b. Pulpotomy and pulpal debridement
    c. Pulpal therapy and regeneration
    d. Apexification/recalcification (endodontists only), limited to ages 6-16
    e. Apicoectomy
    f. Retrograde fillings, per root, per lifetime
14. Periodontic services, limited to:
    a. Two periodontal cleanings following surgery (D4341 is not considered surgery) per plan year after definitive periodontal therapy
    b. Root scaling and planing, once per quadrant, per 24 months
    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 once per two years
    d. Gingivectomy, once per quadrant, per 24 months
    e. Osseous surgery including flap entry and closure, once per quadrant, per 24 months
    f. Provisional splinting
    g. One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site, per lifetime
    h. One full mouth debridement per 36 months
    i. Bone replacement graft
    j. Guided tissue regeneration and biologic materials to aid in osseous tissue regeneration
    k. Mesial/distal wedge procedure, single tooth
    l. Soft tissue allograft

Class III. Major Services:

1. Restoration services, limited to:
    a. 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
2. Prosthetic services, limited to:
    a. Initial placement of dentures
    b. Repair of dentures twice per year, and five total per 5 years
    c. Replacement of dentures that cannot be repaired after 5 years from the date of last placement
    d. Addition of teeth or clasp to existing partial denture
    e. 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)
    f. Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months.
    g. Obturator prosthesis and modification, mandibular resection prosthesis or trismus appliance
    h. Fluoride and/or topical medication carrier for patients undergoing radiation treatment
    i. Tissue conditioning (not covered when performed within 6 months of any denture)
3. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

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.

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 as determined by the Plan.
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 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.

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (GA)

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%	100%
Class II	80%	80%
Class III	50%	50%
Class IV	50%	50%
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: There are no waiting periods.		

- 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 evaluation (D0120, D0145, D0150 or D0160) per six (6) months
2. One limited evaluation or re-evaluation, problem focused (D0140 or D0170) per 6 months
3. One prophylaxis (D1110 or D1120) per six (6) months
4. One fluoride treatment per six (6) months
5. One bitewing x-ray film per six (6) months
6. Periapical x-rays (not on the same date of service as a panoramic radiograph)
7. One full mouth x-ray or panoramic film per 36 months
8. Space maintainer (D1510, D1515) 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
9. One sealant per tooth, per 36 months (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)

Class II. Basic Services:

1. 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)
2. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
3. Crown build-up for non-vital teeth
4. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
5. Prefabricated and stainless steel crowns, once per tooth, per 60 months
6. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
7. 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, 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
8. Recement cast or prefabricated post and core, inlay, crown
9. Therapeutic parenteral drug administration (note medication on claim)
10. Pulp vitality test
11. Diagnostic casts
12. Oral surgery, including postoperative care for:
    a. Removal of teeth except the surgical removal of 3rd molars
    b. Extraction of tooth root or partial tooth
    c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
    d. Tooth re-implantation and/or stabilization; tooth transplantation
13. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
    a. Root canal therapy, once per lifetime per permanent tooth; retreatment of previous root canal therapy, one per lifetime, not within 24 months when done by same dentist or dental office
    b. Pulp caps
    c. Pulpotomy and pulpal debridement
    d. Pulpal therapy
    e. Apexification/recalcification for permanent and primary teeth
    f. Apicoectomy and periradicular surgery
    g. Retrograde fillings, per root, per lifetime
    h. Root amputation
14. Periodontic services, limited to:
    a. Four periodontal cleanings following surgery (D4341 is not considered surgery) per plan year after definitive periodontal therapy
    b. Root scaling and planing, once per quadrant, per 24 months
    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 once per two years
    d. Gingivectomy, once per quadrant, per 24 months
    e. Osseous surgery including flap entry and closure, once per quadrant, per 24 months
    f. Provisional splinting
    g. One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site per 36 months
    h. One full mouth debridement per 36 months
    i. Bone replacement graft, once per quadrant, per 36 months
    j. Guided tissue regeneration and biologic materials to aid in osseous tissue regeneration
    k. Soft tissue allograft, once per quadrant, per 36 months

Class III. Major Services:

1. 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
2. Prosthetic services, limited to:
    a. Initial placement of dentures
    b. Repair of dentures
    c. Replacement of dentures that cannot be repaired after 5 years from the date of last placement
    d. Addition of teeth or clasp to existing partial denture
    e. 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)
    f. Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months.
    g. Tissue conditioning (not covered when performed within 6 months of any denture)
3. Implants and related services
4. 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
5. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

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.

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 as determined by the Plan.
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 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.

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.		

- 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.

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

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DominionNational.com

PID 2754

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 calendar 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); D1575 limited to once per 24 months
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, 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
6. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root or partial tooth
   c. Coronectomy, intentional partial tooth removal, one (1) per lifetime
   d. Alveolectomy, alveoplasty, frenectomy and vestibuloplasty
   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 benign lesion, tumor or cyst and incision and drainage of an abscess or cyst
   h. Biopsy of oral tissue (D7285, D7286)
   i. 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 (D3110 and D3120)
8. Periodontic services, limited to:
   a. Two periodontal cleanings following surgery (D4341 is not considered surgery) per calendar year after definitive periodontal therapy
   b. Root scaling and planing, once per 24 months, per patient, per quadrant
   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 once per two years
   d. Occlusal adjustment performed with covered surgery
   e. Gingivectomy or gingivoplasty, once per 24 months, per patient, per quadrant
   f. Anatomical crown exposure and clinical lengthening
   g. Osseous surgery including flap entry and closure, once per 24 months, per patient, per quadrant
   h. Provisional splinting
   i. One pedicle or free soft tissue graft per site, per lifetime
   j. One full mouth debridement per 24 months
   K. 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)
   l. Periodontal maintenance limited to twice per 12 months

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 tooth
   g. Re-cement crowns/inlays
3. 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
4. Prosthetic services, limited to:
   a. Initial placement of dentures
   b. Repair of dentures
   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
5. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

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.

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. Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Dispensing of drugs.
6. Hospitalization for the following: the operation or treatment for the fitting or wearing of dentures; orthodontic care or malocclusion, operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for the removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and dental implants.
7. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
8. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
9. Services not listed as covered.
10. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function. Bridges are not covered.
11. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
12. Treatment of cleft palate (if not treatable through orthodontics) or neoplasms.
13. Orthodontics is only covered if medically necessary as determined by the Plan. The Invisalign system and similar specialized braces are not a covered benefit. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.

DOMINION® NATIONAL DENTAL

Dominion National Insurance Company

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

- under age 19 -

Service Coverage	**In-Network**	**Out-of Network**
Class I	100%	80%
Class II	80%	60%
Class III	50%	30%
Class IV	50%	0%
Endodontics/Periodontics/ Oral Surgery	Class II Services	Class II Services
Services in Class I - Class IV are listed on the back of this document.		
Annual Deductible	**In-Network**	**Out-of-Network**
Single Child	$25	$25
Two or More Children	$50	$50
Applies to all Services	*No, Waived on Class I and IV Services*	*No, Waived on Class I Services*
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.		

- Deductible is combined for all covered services for each calendar year per pediatric Member – maximum $50 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. Two evaluations (D0120, D0145, D0150, D0160 or D0180) per twelve (12) months
2. One limited evaluation or re-evaluation, problem focused (D0140 or D0170; D0171) per six (6) months
3. One prophylaxis (D1110 or D1120) per six (6) months
4. One fluoride treatment per six (6) months
5. Bitewing x-ray films
6. Periapical x-rays (not on the same date of service as a panoramic radiograph)
7. One full mouth x-ray or panoramic film (D0210 or D0330) every three (3) years
8. Intraoral, extraoral and other radiographic or photographic images (D0240, D0250, D0251, D0340, D0350 or D0351)
9. Fixed and removable space maintainer (D1510, D1515, D1520 and D1525) 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)
10. One sealant per tooth, per 60 months, (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)
11. Professional visits/calls for observations, consultations & behavior mgmt - office, house, hospital or other inpatient/outpatient facility
12. Cone beam images; Maxillofacial images, ultrasounds and MRIs
13. Diagnostic tests and examinations, including collection, preparation, accession, processing and analysis of viral cultures, samples and smears
14. Caries risk assessment and documentation
15. Diagnostic imaging with interpretation

Class II. Basic Services:

1. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations); gold foil; protective restorations when not billed on the same day as a normal restoration
2. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
3. Crown build-up for non-vital teeth
4. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
5. Prefabricated crowns
6. Temporary crowns for a fractured tooth
7. 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
8. General anesthesia and analgesic, including intravenous and nonintravenous sedation with a 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
9. Athletic mouthguard; occlusal guard including limited and complete adjustments
10. Recement cast or prefabricated post and core, inlay, crown
11. Administration/application of therapeutic parenteral drug, other drugs and/or medicaments
12. Other oral pathology procedures, by report
13. Coping
14. Oral surgery, including postoperative care for:
    a. Removal of teeth except the surgical removal of 3rd molars
    b. Extraction of tooth root or partial tooth
    c. Coronectomy, intentional partial tooth removal
    d. Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty
    e. Excision of periocoronal gingiva or hyperplastic tissue and excision of oral tissue for biopsy
    f. Tooth re-implantation and/or stabilization; tooth transplantation
    g. Incision and drainage of an abscess or cyst
    h. Mobilization of erupted or malpositioned tooth, covered for all teeth except 3rd molars
    i. Placement of device to facilitate eruption of impacted tooth (indicate if orthodontia related)
    j. Exfoliative cytological sample collection
    k. Radical resection of maxilla or mandible
    l. Other oral surgery procedures and related services
15. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
    a. 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 dentist or dental office
    b. Pulp caps
    c. Pulpotomy and pulpal debridement
    d. Pulpal therapy and regeneration
    e. Apexification/recalcification (endodontists only)
    f. Apicoectomy
    g. Periradicular surgery
    h. Root amputation
    i. Surgical procedure for isolation of tooth with rubber dam
    j. Hemisection
    k. Canal prep and fitting of preformed dowel or post
    f. Retrograde fillings
16. Periodontic services, limited to:
    a. Two periodontal cleanings following surgery (D4341 is not considered surgery) per plan year after definitive periodontal therapy
    b. Root scaling and planing, once per quadrant, per six (6) months
    c. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110
    d. Gingivectomy and gingivoplasty
    e. Gingival flap procedure, including root planing
    f. Osseous surgery including flap entry and closure
    g. Pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site
    h. Full mouth debridement
    i. Bone replacement graft
    j. Guided tissue regeneration and biologic materials to aid in osseous tissue regeneration
    k. Distal or proximal wedge procedure
    l. Soft tissue allograft
    m. Apically positioned flap
    n. Clinical crown lengthening
    o. Biologic materials to aid soft and osseous tissue regeneration
    p. Surgical revision
    q. Provisional splinting
    r. Localized delivery of antimicrobial agents

Class III. Major Services:

1. Restoration services, limited to:
    a. Study model (diagnostic cast)
    b. 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
    c. Post removal
2. Prosthetic services, limited to:
    a. Initial placement of dentures
    b. Pediatric partial denture including removable unilateral partial dentures/dentures
    c. Repair of dentures
    d. Replacement of dentures that cannot be repaired
    e. Addition of teeth or clasp to existing partial denture
    f. 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)
    g. Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months.
    h. Obturator prosthesis and modification, mandibular resection prosthesis or trismus appliance
    i. Fluoride and/or topical medication carrier for patients undergoing radiation treatment; radiation carrier, shield and cone locator

j. Tissue conditioning
k. Precision attachment
l. Prosthesis (nasal, orbital, ocular, facial, nasal septal, cranial, speech and feeding aid), including cleaning, maintenance, adjustments, modifications, repairs and replacement
m. Palatal Prosthesis (palatal augmentation, palatal lift prosthesis - definitive, interim and modification)
n. Commissure and surgical splints and stents
o. Other maxillofacial prosthetics including adjustments and appliance removal

3. Implants and related services
4. Odontoplasty
5. Internal bleaching
6. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

Class IV. *MEDICALLY NECESSARY* Orthodontia Services:

1. Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy
2. Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/ psychological condition of the child
3. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility

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. 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. Hospitalization for any dental procedure.
6. 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.
7. Services not listed as covered.
8. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
9. 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.
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, malignancies or neoplasms, except in the case of newborn children.
12. Orthodontics is only covered if medically necessary as determined by the Plan. The Invisalign system and similar specialized braces are not a covered service.
13. No service will be paid for any surgical, adjunctive or prosthetic service not listed above unless the Covered Child had New Jersey Benchmark Medical Coverage in effect on the date the service was rendered, and the Covered Child or Responsible Party has submitted to the Plan a copy of the medical carrier's explanation of services showing that the service was not covered under the Benchmark Medical Coverage. "Benchmark Medical Coverage"means medical coverage that is provided by a carrier that is a qualified health plan in the State of New Jersey and satisfies the benchmark plan requirement for medical essential health services in New Jersey.

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (OR)

Coverage Schedule for Pediatric Services (under age 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: There are no waiting periods.		

- 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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PID 3582

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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, D0160, or D0180) per twelve (12) months; coverage for all evaluations by medical practioners who are oral surgeons
2. Limited evaluation or re-evaluation, problem focused (D0140 or D0170) do not count against annual exam frequency limitation
3. One prophylaxis (D1110 or D1120) per six (6) months
4. One fluoride treatment per six (6) months (additional topical fluoride treatments may be available when high risk conditions or oral health factors are present)
5. Four bitewing x-ray films per six (6) months
6. Periapical x-rays limited to six (6) flims per 12 months under age six (not on the same date of service as a panoramic radiograph)
7. One full mouth x-ray or panoramic film (starting at age six) per 36 months
8. 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)
9. One sealant per tooth, per 60 months, (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)

Class II. Basic Services:

1. 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
2. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
3. Crown build-up for non-vital teeth
4. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
5. Prefabricated crowns, once per tooth, per 60 months
6. Temporary crowns for a fractured tooth
7. 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
8. 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
9. Occlusal guard with covered surgery, by report
10. Recement cast or prefabricated post and core, inlay, crown
11. Therapeutic parenteral drug administration (note medication on claim)
12. Oral surgery, including postoperative care for:
    a. Removal of teeth except the surgical removal of 3rd 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)
    b. Extraction of tooth root or partial tooth
    c. Coronectomy, intentional partial tooth removal
    d. Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty
    e. Excision of periocoronal gingiva or hyperplastic tissue and excision of oral tissue for biopsy
    f. Tooth re-implantation and/or stabilization; tooth transplantation
    g. Incision and drainage of an abscess or cyst
    h. Biopsy of oral tissue (D7285, D7286)
13. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
    a. 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
    b. Pulp cap
    c. Pulpotomy and pulpal debridement
    d. Pulpal therapy and regeneration
    e. Apexification/recalcification (endodontists only)
    f. Apicoectomy
    g. Retrograde fillings

14. Periodontic services, limited to:
    a. One periodontal cleaning following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years, per six months
    b. Root scaling and planing, once per quadrant, per 24 months
    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 once per two years.
    d. Gingivectomy/gingivoplasty (D4210/D4211), limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures
    e. Osseous surgery including flap entry and closure, once per quadrant
    f. One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site, per lifetime
    g. One full mouth debridement per 24 months

Class III. Major Services:

1. Restoration services, limited to:
    a. 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
2. 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
3. Prosthetic services, limited to:
    a. 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
    b. Repair of dentures
    c. 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
    d. Addition of teeth or clasp to existing partial denture
    e. 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)
    f. Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months.
    g. Fluoride gel carrier for patients with severe oral disease
    h. Tissue conditioning (not covered when performed within 6 months of any denture)
4. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available)

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 or members with the ICD-10-CM diagnosis of cleft palate or cleft palate with cleft lip.

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, 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. 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 lostby 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 beconsistently 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.

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (PA)

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: There are no waiting periods.		

- 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.

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. One (1) evaluation (D0120, D0140, D0150 or D0180) per six (6) months, per patient; D0160 is covered
2. One (1) prophylaxis (D1110 or D1120) per six (6) months, per patient
3. One (1) fluoride treatment is covered every six (6) months, per patient
4. Bitewing x-rays, one (1) set per six (6) months
5. Periapical x-rays (not on the same date of service as a panoramic radiograph)
6. One (1) full mouth x-ray or panoramic film, per 60 months; maximum of one (1) set of x-rays per office visit
7. Space maintainer (D1515 or D1525) 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
8. One (1) sealant per tooth, per 36 months (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)

Class II. Basic Services:

1. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)
2. Pin retention of fillings (multiple pins on the same tooth are allowable as one (1) pin)
3. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
4. 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
5. Occlusal guard, analysis and limited/complete adjustment, one (1) in 12 months for patients 13 and older, by report.
6. Prefabricated stainless steel or porcelain crown for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling, limited to one (1) per 60 months from the original date of placement, per permanent tooth, per patient
7. Addition of teeth to existing partial denture
8. One (1) relining or rebasing of existing removable dentures per 36 months; only after six (6) months from date of last placement, unless an immediate prosthesis replacing at least three (3) teeth
9. Repair of crowns, dentures and bridges
10. 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
11. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    a. Root canal therapy; retreatment of previous root canal therapy
    b. Pulpotomy
    c. Apicoectomy
    d. Retrograde fillings per root, per lifetime
12. Periodontic services, limited to:
    a. Two (2) periodontal cleanings, in addition to adult prophylaxis, per plan year, within 24 months after definitive periodontal therapy
    b. One (1) root scaling and planing per 24 months, per patient, per quadrant
    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 once per two years
    d. Gingivectomy, one (1) per 36 months per patient, per quadrant
    e. Osseous surgery including flap entry and closure, one (1) per 36 months per patient, per quadrant
    f. Pedicle or free soft tissue graft
    g. One (1) full mouth debridement per lifetime

Class III. Major Services:

1. One (1) study model per 36 months
2. Restoration services, limited to:
    a. 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 .
    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
3. Prosthetic services, limited to:
    a. Initial placement of dentures
    b. Replacement of dentures that cannot be repaired after five (5) years from the date of last placement
    c. Construction of bridges, replacement limited to one (1) per 60 months
    d. Implants and related services; replacement of implant crowns limited to one (1) in 60 months
    e. 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
4. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per plan year (when available)

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.

Plan Exclusions

1. Services which are covered under worker's compensation, employer's liability laws or the Pennsylvania Motor Vehicle Financial Responsibility Law.
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

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 in and out-of-network for all covered services for each calendar year per pediatric Member – maximum $100 for pediatric Members.
- The single child deductible and out-of-pocket maximum amounts must be met by one child prior to satisfying the two or more children deductible and out-of-pocket maximum amounts.
- 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); D1575 limited to once per 24 months
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; 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
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. Coronectomy, intentional partial tooth removal, one (1) per lifetime
    d. Alveoplasty, frenectomy and frenuloplasty
    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 lesion, tumor or cyst and incision and drainage of an abscess or cyst
    h. Removal of oral tissue, odontogenic cyst, torus palatinus and mandibularis (D7285, D7286)
    i. Oroantral fistula closure and primary closure of a sinus perforation
    j. Biopsy
    k. 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
    b. Pulpotomy and pulp cap
    c. Pulpal therapy and pulpal debridement
    d. Pulpal regeneration
    e. Apexification/recalcification limited to one (1) per tooth, per provider, per lifetime; D3352 limited to three (3) treatments per tooth, per provider, 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. 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
    d. Occlusal adjustment performed with covered surgery
    e. Gingivectomy or gingivoplasty, once per 24 months, per quadrant, per patient
    f. Osseous surgery including flap entry and closure, once per 24 months, per quadrant, per patient
    g. Provisional splinting
    h. Pedicle, subepithelial, bone replacement or free soft tissue graft
    i. 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

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

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 limited to once per lifetime and 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.