The dental plan is underwritten by Dominion Dental Services, Inc., d/b/a Dominion National (hereinafter referred to as "Dominion").

DOMINION® NATIONAL DENTAL

Choice PPO

Coverage Schedule, Limitations and Exclusions

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

Annual Deductible	In-Network	Out-of-Network
Amount	$0	$0
Maximum Per Family	$0	$0
Applies to	N/A	N/A

Maximums	In-Network	Out-of-Network
Annual	$1,250	$1,250
Lifetime Orthodontic	$1,000	$1,000

- The maximum listed is the dollar amount that the plan will pay towards the cost of dental care within the specified period per member.
- The annual maximum is combined for in-network and out-of-network services.
- The annual maximum applies to: Class 1, Class 2, Class 3

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	90th

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

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

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

			In-Network			Out-of-Network		
Service Class	Service Description	Service Limitation	Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar Year including a maximum of one comprehensive evaluation per 36 months	100%	None	No	100%	None	No
1	Emergency or problem focused exam (D0140)	One per Calendar Year	100%	None	No	100%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year; one additional cleaning is covered for expecting mothers or Diabetics	100%	None	No	100%	None	No
1	Prevention Reward	Primary subscriber will receive a $20 payment from Dominion for each family member that receives two cleanings during the Calendar Year from a participating PPO network dentist. Contact your Benefit Administrator for details.	100%	None	No	100%	None	No
1	Topical fluoride	One per Calendar Year, to age 16	100%	None	No	100%	None	No
1	Bitewing x-rays	2 per Calendar Year	100%	None	No	100%	None	No
1	Periapical x-rays		100%	None	No	100%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	100%	None	No
1	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service.	100%	None	No	100%	None	No
1	Sealants	One per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)	100%	None	No	100%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Limited to two per Calendar Year	100%	None	No	100%	None	No
2	Simple extraction of teeth		100%	None	No	100%	None	No
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Per tooth, per surface every 24 months	100%	None	No	100%	None	No
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	100%	None	No	100%	None	No
2	Antibiotic injections administered by a dentist		100%	None	No	100%	None	No
2	Space maintainers	Used to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)	100%	None	No	100%	None	No

			In-Network			Out-of-Network		
Service Class	Service Description	Service Limitation	Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
2	Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst		100%	None	No	100%	None	No
2	Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal	One per tooth per lifetime	100%	None	No	100%	None	No
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to root canal therapy	Not covered if pulp chamber was opened before effective date of coverage	100%	None	No	100%	None	No
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		100%	None	No	100%	None	No
2	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to retrograde fillings	One per root per lifetime	100%	None	No	100%	None	No
2	Periodontic services, limited to periodontal maintenance	Two per Calendar Year following surgery	100%	None	No	100%	None	No
2	Periodontic services, limited to root scaling and planing	One per quadrant per 24 months from age 21	100%	None	No	100%	None	No
2	Periodontic services, limited to: occlusal adjustment performed with covered surgery; gingivectomy; osseous surgery including flap entry and closure		100%	None	No	100%	None	No
2	Periodontic services, limited to pedicle or free soft tissue graft	One per site per lifetime	100%	None	No	100%	None	No
2	Periodontic services, limited to occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	100%	None	No	100%	None	No
2	Periodontic services, limited to full mouth debridement	One per lifetime	100%	None	No	100%	None	No
2	Periodontic services, limited to scaling in presence of generalized moderate or severe gingival inflammation	Full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years	100%	None	No	100%	None	No

			In-Network			Out-of-Network		
Service Class	Service Description	Service Limitation	Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Study model	One per 36 months	80%	None	No	80%	None	No
3	Crown build-up for non-vital teeth		80%	None	No	80%	None	No
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	80%	None	No	80%	None	No
3	Repair of dentures or fixed bridgework	One per 24 months	80%	None	No	80%	None	No
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery or periodontal surgery	80%	None	No	80%	None	No
3	Infiltration of sustained release therapeutic drug - single or multiple sites		80%	None	No	80%	None	No
3	Restoration services, limited to cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown	Limited to a tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	80%	None	No	80%	None	No
3	Restoration services, limited to replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	80%	None	No	80%	None	No
3	Restoration services, limited to stainless steel crowns	Up to age 14 (one per tooth per lifetime)	80%	None	No	80%	None	No
3	Restoration services, limited to post and core	Covered in addition to a crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	80%	None	No	80%	None	No
3	Prosthetic services, limited to initial placement of removable dentures or fixed bridges		80%	None	No	80%	None	No
3	Prosthetic services, limited to replacement of removable dentures or fixed bridges	That cannot be repaired after 7 years from the date of last placement	80%	None	No	80%	None	No
3	Prosthetic services, limited to addition of teeth to existing partial denture		80%	None	No	80%	None	No
3	Prosthetic services, limited to relining or rebasing of existing removable dentures	One per 24 months (only after 24 months from date of last placement)	80%	None	No	80%	None	No
4	Orthodontia Services	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	60%	None	No	60%	None	No

Plan Exclusions

Please refer to the section in your Certificate of Coverage titled “State-Specific Exclusions” for additional exclusions, if applicable.

1. Services which are covered under worker’s compensation or employer’s liability laws
2. Services which are not necessary for the patient’s dental health as determined by the plan.
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 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 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 nonpathologic, asymptomatic impacted teeth including third molars.
12. Procedures not listed as covered services under this plan.
13. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that 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. Implants and related services, including implant removal.