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

DOMINION® NATIONAL DENTAL

Elite PPO Premium (DC) Coverage Schedule, Limitations and Exclusions for Adult Services (age 19 and over)

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	90%	None
2	Basic Services	80%	6 months	70%	6 months
3	Major Services	50%	12 months	40%	12 months
4	Orthodontic Services	0%	N/A	0%	N/A

Annual Deductible	In-Network	Out-of-Network
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies To	Class 2 and Class 3	Class 2 and Class 3

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible. For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.

Maximums	In-Network	Out-of-Network
Annual	$1,500	$1,500
Lifetime Orthodontic	N/A	N/A

- 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 and Class 3.

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

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

- Waiting period credit will be given for the length of time Member was covered under each benefit classification under the current employer's prior dental plan.
- If course of treatment is to exceed $300, prior review is recommended.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar Year including a maxmium of one comprehensive evaluation per 36 months	100%	None	No	90%	None	No
1	Emergency or problem focused exam	One per Calendar Year	100%	None	No	90%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	100%	None	No	90%	None	No
1	Prevention Rewards	Primary subscriber will receive a $20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist	100%	None	No	90%	None	No
1	Bitewing x-rays	Two per Calendar Year	100%	None	No	90%	None	No
1	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	No	90%	None	No
1	Periapical x-rays		100%	None	No	90%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	90%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	90%	None	No
2	Simple extraction of teeth		80%	6 months	Yes	70%	6 months	Yes
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months	80%	6 months	Yes	70%	6 months	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	6 months	Yes	70%	6 months	Yes
2	Antibiotic injections administered by a dentist		80%	6 months	Yes	70%	6 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	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; marsupialization of odontogenic cyst		50%	12 months	Yes	40%	12 months	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Study model	One per 36 months	50%	12 months	Yes	40%	12 months	Yes
3	Crown build-up for non-vital teeth		50%	12 months	Yes	40%	12 months	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	50%	12 months	Yes	40%	12 months	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	50%	12 months	Yes	40%	12 months	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	50%	12 months	Yes	40%	12 months	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	One per two years	50%	12 months	Yes	40%	12 months	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Prosthetic services, limited to: addition of teeth to existing partial denture	Per tooth	50%	12 months	Yes	40%	12 months	Yes
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)	50%	12 months	Yes	40%	12 months	Yes
4	Orthodontia Services Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

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

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

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium (DE) Coverage Schedule, Limitations and Exclusions for Adult Services (age 19 and over)

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	90%	None
2	Basic Services	80%	6 months	70%	6 months
3	Major Services	50%	12 months	40%	12 months
4	Orthodontic Services	0%	N/A	0%	N/A

Annual Deductible	In-Network	Out-of-Network
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies To	Class 2 and Class 3	Class 2 and Class 3

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible. For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.

Maximums	In-Network	Out-of-Network
Annual	$1,500	$1,500
Lifetime Orthodontic	N/A	N/A

- 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 and Class 3.

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

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

- Waiting period credit will be given for the length of time Member was covered under each benefit classification under the current employer's prior dental plan.
- If course of treatment is to exceed $300, prior review is recommended.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar Year including a maxmium of one comprehensive evaluation per 36 months	100%	None	No	90%	None	No
1	Emergency or problem focused exam	One per Calendar Year	100%	None	No	90%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	100%	None	No	90%	None	No
1	Prevention Rewards	Primary subscriber will receive a $20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist.	100%	None	No	90%	None	No
1	Bitewing x-rays	Two per Calendar Year	100%	None	No	90%	None	No
1	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	No	90%	None	No
1	Periapical x-rays		100%	None	No	90%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	90%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	90%	None	No
2	Simple extraction of teeth		80%	6 months	Yes	70%	6 months	Yes
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months	80%	6 months	Yes	70%	6 months	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	6 months	Yes	70%	6 months	Yes
2	Antibiotic injections administered by a dentist		80%	6 months	Yes	70%	6 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	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; marsupialization of odontogenic cyst		50%	12 months	Yes	40%	12 months	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Study model	One per 36 months	50%	12 months	Yes	40%	12 months	Yes
3	Crown build-up for non-vital teeth		50%	12 months	Yes	40%	12 months	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	50%	12 months	Yes	40%	12 months	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	50%	12 months	Yes	40%	12 months	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	50%	12 months	Yes	40%	12 months	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	One per two years	50%	12 months	Yes	40%	12 months	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Prosthetic services, limited to: addition of teeth to existing partial denture	Per tooth	50%	12 months	Yes	40%	12 months	Yes
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)	50%	12 months	Yes	40%	12 months	Yes
4	Orthodontia Services Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

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

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

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium (MD)
Coverage Schedule, Limitations and Exclusions for Adult Services

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	90%	None
2	Basic Services	80%	6 months	70%	6 months
3	Major Services	50%	12 months	40%	12 months
4	Orthodontic Services	0%	N/A	0%	N/A

Annual Deductible	In-Network	Out-of-Network
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies to	Class 2 and Class 3	Class 2 and Class 3

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible. For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.

Maximums	In-Network	Out-of-Network
Annual	$1,500	$1,500
Lifetime Orthodontic	N/A	N/A

- 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 and Class 3

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

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

- Waiting period credit will be given for the length of time Member was covered under each benefit classification under their prior dental plan.
- If course of treatment is to exceed $300, prior review is recommended.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar year including a maxmium of one comprehensive evaluation per 36 months	100%	None	No	90%	None	No
1	Emergency or problem focused exam	One per Calendar year	100%	None	No	90%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar year	100%	None	No	90%	None	No
1	Prevention Rewards	Primary subscriber will receive a $20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist	100%	None	No	90%	None	No
1	Bitewing x-rays	Two per Calendar year	100%	None	No	90%	None	No
1	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	No	90%	None	No
1	Periapical x-rays		100%	None	No	90%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	90%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	90%	None	No
2	Simple extraction of teeth		80%	6	Yes	70%	6	Yes
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months	80%	6	Yes	70%	6	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	6	Yes	70%	6	Yes
2	Antibiotic injections administered by a dentist		80%	6	Yes	70%	6	Yes
3	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; marsupialization of odontogenic cyst		50%	12	Yes	40%	12	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	50%	12	Yes	40%	12	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	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	50%	12	Yes	40%	12	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		50%	12	Yes	40%	12	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	12	Yes	40%	12	Yes
3	Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One per lifetime	50%	12	Yes	40%	12	Yes
3	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	50%	12	Yes	40%	12	Yes
3	Study model	One per 36 months	50%	12	Yes	40%	12	Yes
3	Crown build-up for non-vital teeth		50%	12	Yes	40%	12	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	50%	12	Yes	40%	12	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	50%	12	Yes	40%	12	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	50%	12	Yes	40%	12	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	12	Yes	40%	12	Yes
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	50%	12	Yes	40%	12	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	50%	12	Yes	40%	12	Yes
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	50%	12	Yes	40%	12	Yes
3	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	One per two years	50%	12	Yes	40%	12	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		50%	12	Yes	40%	12	Yes
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	50%	12	Yes	40%	12	Yes
3	Prosthetic services, limited to: addition of teeth to existing partial denture	Per tooth	50%	12	Yes	40%	12	Yes
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)	50%	12	Yes	40%	12	Yes
4	Orthodontia Services (medically necessary) Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

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

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

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium (PA)
Coverage Schedule, Limitations and Exclusions for Adult Services (age 19 and over)

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	90%	None
2	Basic Services	80%	6 months	70%	6 months
3	Major Services	50%	12 months	40%	12 months
4	Orthodontic Services	0%	N/A	0%	N/A

Annual Deductible	In-Network	Out-of-Network
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies To	Class 2 and Class 3	Class 2 and Class 3

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible. For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.

Maximums	In-Network	Out-of-Network
Annual	$1,500	$1,500
Lifetime Orthodontic	N/A	N/A

- 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 and Class 3.

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

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

- Waiting period credit will be given for the length of time Member was covered under each benefit classification under the current employer's prior dental plan.
- If course of treatment is to exceed $300, prior review is recommended.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar Year including a maxmium of one comprehensive evaluation per 36 months	100%	None	No	90%	None	No
1	Emergency or problem focused exam	One per Calendar Year	100%	None	No	90%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	100%	None	No	90%	None	No
1	Prevention Rewards	Primary subscriber will receive a $20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist.	100%	None	No	90%	None	No
1	Bitewing x-rays	Two per Calendar Year	100%	None	No	90%	None	No
1	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	No	90%	None	No
1	Periapical x-rays		100%	None	No	90%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	90%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	90%	None	No
2	Simple extraction of teeth		80%	6 months	Yes	70%	6 months	Yes
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months	80%	6 months	Yes	70%	6 months	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	6 months	Yes	70%	6 months	Yes
2	Antibiotic injections administered by a dentist		80%	6 months	Yes	70%	6 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	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; marsupialization of odontogenic cyst		50%	12 months	Yes	40%	12 months	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Study model	One per 36 months	50%	12 months	Yes	40%	12 months	Yes
3	Crown build-up for non-vital teeth		50%	12 months	Yes	40%	12 months	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	50%	12 months	Yes	40%	12 months	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	50%	12 months	Yes	40%	12 months	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	50%	12 months	Yes	40%	12 months	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	One per two years	50%	12 months	Yes	40%	12 months	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Prosthetic services, limited to: addition of teeth to existing partial denture	Per tooth	50%	12 months	Yes	40%	12 months	Yes
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)	50%	12 months	Yes	40%	12 months	Yes
4	Orthodontia Services Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

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

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

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium (VA)
Coverage Schedule, Limitations and Exclusions for Adult Services (age 19 and over)

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	90%	None
2	Basic Services	80%	6 months	70%	6 months
3	Major Services	50%	12 months	40%	12 months
4	Orthodontic Services	0%	N/A	0%	N/A

Annual Deductible	In-Network	Out-of-Network
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies To	Class 2 and Class 3	Class 2 and Class 3

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible. For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.

Maximums	In-Network	Out-of-Network
Annual	$1,500	$1,500
Lifetime Orthodontic	N/A	N/A

- 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 and Class 3.

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

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

- Waiting period credit will be given for the length of time Member was covered under each benefit classification under the current employer's prior dental plan.
- If course of treatment is to exceed $300, prior review is recommended.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar Year including a maxmium of one comprehensive evaluation per 36 months	100%	None	No	90%	None	No
1	Emergency or problem focused exam	One per Calendar Year	100%	None	No	90%	None	No
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	100%	None	No	90%	None	No
1	Prevention Rewards	Primary subscriber will receive a $20 payment from Dominion for each family member that receives two cleanings during the Calendar year from a participating Elite PPO network dentist.	100%	None	No	90%	None	No
1	Bitewing x-rays	Two per Calendar Year	100%	None	No	90%	None	No
1	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	No	90%	None	No
1	Periapical x-rays		100%	None	No	90%	None	No
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	No	90%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	90%	None	No
2	Simple extraction of teeth		80%	6 months	Yes	70%	6 months	Yes
2	Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)	Excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months	80%	6 months	Yes	70%	6 months	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	6 months	Yes	70%	6 months	Yes
2	Antibiotic injections administered by a dentist		80%	6 months	Yes	70%	6 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	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; marsupialization of odontogenic cyst		50%	12 months	Yes	40%	12 months	Yes
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal, impacted teeth only	One per tooth per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		50%	12 months	Yes	40%	12 months	Yes
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Periodontic services, limited to: Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One per lifetime	50%	12 months	Yes	40%	12 months	Yes
3	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	50%	12 months	Yes	40%	12 months	Yes
3	Study model	One per 36 months	50%	12 months	Yes	40%	12 months	Yes
3	Crown build-up for non-vital teeth		50%	12 months	Yes	40%	12 months	Yes
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	50%	12 months	Yes	40%	12 months	Yes
3	Repair of dentures or fixed bridgework	One per 24 months	50%	12 months	Yes	40%	12 months	Yes
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	50%	12 months	Yes	40%	12 months	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes
3	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	One per two years	50%	12 months	Yes	40%	12 months	Yes
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		50%	12 months	Yes	40%	12 months	Yes
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	50%	12 months	Yes	40%	12 months	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Prosthetic services, limited to: addition of teeth to existing partial denture	Per tooth	50%	12 months	Yes	40%	12 months	Yes
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)	50%	12 months	Yes	40%	12 months	Yes
4	Orthodontia Services Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

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

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