DOMINION NATIONAL
DENTAL

Choice PPO Basic (DC)

Benefit Coverage	In-Network			Out-of Network		
Year	**1st**	**2nd**	**3rd**	**1st**	**2nd**	**3rd**
Class I	100%	100%	100%	90%	90%	90%
Class II	50%	60%	80%	30%	50%	70%
Class III	15%	25%	50%	10%	20%	40%
Class IV	0%			0%		
Endo/Perio	Class III Benefits			Class III Benefits		
Annual Deductible	**In-Network**			**Out-of-Network**		
Amount	$50			$50		
Max Per Family	$150			$150		
Applies to all Benefits	*Yes*			*Yes*		
Maximums	**In-Network**			**Out-of-Network**		
Annual	$1,000			$1,000		
Lifetime Ortho	N/A			N/A		
* Annual Maximum applies to Class I, Class II and Class III Benefits.						
	In-Network			**Out-of-Network**		
Out-of-Network Allowance	N/A			MAC		
Waiting Periods	**In-Network**			**Out-of-Network**		
Class I	NONE			NONE		
Class II	NONE			NONE		
Class III	NONE			NONE		
Class IV	NONE			NONE		

- Deductible is combined for all services for each calendar year per Member – maximum $150 per family.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

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

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

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

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. One topical fluoride per Calendar Year, to age 16
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Class III. Major Services:

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. Gingivectomy
   e. Osseous surgery including flap entry and closure
   f. One pedicle or free soft tissue graft per site per lifetime
   g. One appliance (night guards) per five years within 6 months of osseous surgery
   h. One full mouth debridement per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Gold or porcelain inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced
   c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
   d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months

Class IV. Orthodontia Services: Not Covered

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

Plan Exclusions:

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

DOMINION NATIONAL
DENTAL

Choice PPO Basic (DE)

Benefit Coverage	In-Network			Out-of Network		
Year	**1st**	**2nd**	**3rd**	**1st**	**2nd**	**3rd**
Class I	100%	100%	100%	90%	90%	90%
Class II	50%	60%	80%	30%	50%	70%
Class III	15%	25%	50%	10%	20%	40%
Class IV	0%			0%		
Endo/Perio	Class III Benefits			Class III Benefits		
Annual Deductible	**In-Network**			**Out-of-Network**		
Amount	$50			$50		
Max Per Family	$150			$150		
Applies to all Benefits	*Yes*			*Yes*		
Maximums	**In-Network**			**Out-of-Network**		
Annual	$1,000			$1,000		
Lifetime Ortho	N/A			N/A		
* Annual Maximum applies to Class I, Class II and Class III Benefits.						
	In-Network			**Out-of-Network**		
Out-of-Network Allowance	N/A			MAC		
Waiting Periods	**In-Network**			**Out-of-Network**		
Class I	NONE			NONE		
Class II	NONE			NONE		
Class III	NONE			NONE		
Class IV	NONE			NONE		

- Deductible is combined for all services for each calendar year per Member – maximum $150 per family.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

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DominionNational.com

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

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. One topical fluoride per Calendar Year, to age 16
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Class III. Major Services:

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. Gingivectomy
   e. Osseous surgery including flap entry and closure
   f. One pedicle or free soft tissue graft per site per lifetime
   g. One appliance (night guards) per five years within 6 months of osseous surgery
   h. One full mouth debridement per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Gold or porcelain inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced
   c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
   d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months

Class IV. Orthodontia Services: Not Covered

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

Plan Exclusions:

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

DOMINION NATIONAL
DENTAL

Choice PPO Basic (MD)

Benefit Coverage	In-Network			Out-of Network		
Year	**1st**	**2nd**	**3rd**	**1st**	**2nd**	**3rd**
Class I	100%	100%	100%	90%	90%	90%
Class II	50%	60%	80%	30%	50%	70%
Class III	15%	25%	50%	10%	20%	40%
Class IV	0%			0%		
Endo/Perio	Class III Benefits			Class III Benefits		
Annual Deductible	**In-Network**			**Out-of-Network**		
Amount	$50			$50		
Max Per Family	$150			$150		
Applies to all Benefits	*Yes*			*Yes*		
Maximums	**In-Network**			**Out-of-Network**		
Annual	$1,000			$1,000		
Lifetime Ortho	N/A			N/A		
* Annual Maximum applies to Class I, Class II and Class III Benefits.						
	In-Network			**Out-of-Network**		
Out-of-Network Allowance	N/A			MAC		
Waiting Periods	**In-Network**			**Out-of-Network**		
Class I	NONE			NONE		
Class II	NONE			NONE		
Class III	NONE			NONE		
Class IV	NONE			NONE		

- Deductible is combined for all services for each calendar year per Member – maximum $150 per family.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

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

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. One topical fluoride per Calendar Year, to age 16
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Class III. Major Services:

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a.Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. Gingivectomy
   e. Osseous surgery including flap entry and closure
   f. One pedicle or free soft tissue graft per site per lifetime
   g. One appliance (night guards) per 5 years within 6 months of osseous surgery
   h. One full mouth debridement per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Gold or porcelain inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced
   c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
   d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months

Class IV. Orthodontia Services: Not Covered

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

Plan Exclusions:

1. Services which are covered under worker's compensation or employer's liability laws
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.
18. Maryland policyholders only: Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

DOMINION NATIONAL
DENTAL

Choice PPO Basic (PA)

Benefit Coverage	In-Network			Out-of Network		
Year	**1st**	**2nd**	**3rd**	**1st**	**2nd**	**3rd**
Class I	100%	100%	100%	90%	90%	90%
Class II	50%	60%	80%	30%	50%	70%
Class III	15%	25%	50%	10%	20%	40%
Class IV	0%			0%		
Endo/Perio	Class III Benefits			Class III Benefits		
Annual Deductible	**In-Network**			**Out-of-Network**		
Amount	$50			$50		
Max Per Family	$150			$150		
Applies to all Benefits	*Yes*			*Yes*		
Maximums	**In-Network**			**Out-of-Network**		
Annual	$1,000			$1,000		
Lifetime Ortho	N/A			N/A		
* Annual Maximum applies to Class I, Class II and Class III Benefits.						
	In-Network			**Out-of-Network**		
Out-of-Network Allowance	N/A			MAC		
Waiting Periods	**In-Network**			**Out-of-Network**		
Class I	NONE			NONE		
Class II	NONE			NONE		
Class III	NONE			NONE		
Class IV	NONE			NONE		

- Deductible is combined for all services for each calendar year per Member – maximum $150 per family.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

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

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. One topical fluoride per Calendar Year, to age 16
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Class III. Major Services:

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. Gingivectomy
   e. Osseous surgery including flap entry and closure
   f. One pedicle or free soft tissue graft per site per lifetime
   g. One appliance (night guards) per 5 years within 6 months of osseous surgery
   h. One full mouth debridement per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Gold or porcelain inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced
   c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
   d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months

Class IV. Orthodontia Services: Not Covered

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

Plan Exclusions:

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

DOMINION NATIONAL DENTAL

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

Choice PPO Basic (VA)

Benefit Coverage	**In-Network**			**Out-of Network**		
Year	**1st**	**2nd**	**3rd**	**1st**	**2nd**	**3rd**
Class I	100%	100%	100%	90%	90%	90%
Class II	50%	60%	80%	30%	50%	70%
Class III	15%	25%	50%	10%	20%	40%
Class IV	0%			0%		
Endo/Perio	Class III Benefits			Class III Benefits		
Annual Deductible	**In-Network**			**Out-of-Network**		
Amount	$50			$50		
Max Per Family	$150			$150		
Applies to all Benefits	*Yes*			*Yes*		
Maximums	**In-Network**			**Out-of-Network**		
Annual	$1,000			$1,000		
Lifetime Ortho	N/A			N/A		
* Annual Maximum applies to Class I, Class II and Class III Benefits.						
	In-Network			**Out-of-Network**		
Out-of-Network Allowance	N/A			MAC		
Waiting Periods	**In-Network**			**Out-of-Network**		
Class I	NONE			NONE		
Class II	NONE			NONE		
Class III	NONE			NONE		
Class IV	NONE			NONE		

- Deductible is combined for all services for each calendar year per Member – maximum $150 per family.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

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

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

Class I. Diagnostic and Preventive Services:

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. One topical fluoride per Calendar Year, to age 16
5. Bitewing x-rays, 2 per Calendar Year
6. Periapical x-rays
7. One full mouth or panoramic x-ray per 60 months
8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)

Class III. Major Services:

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year (D4341 is not considered surgery)
   b. One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. Gingivectomy
   e. Osseous surgery including flap entry and closure
   f. One pedicle or free soft tissue graft per site per lifetime
   g. One appliance (night guards) per 5 years within 6 months of osseous surgery
   h. One full mouth debridement per lifetime
4. One study model per 36 months
5. Crown build-up for non-vital teeth
6. Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery
9. Restoration services, limited to:
   a. Gold or porcelain inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced
   c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
   d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months

Class IV. Orthodontia Services: Not Covered

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

Plan Exclusions:

1. Services which are covered under Medicare, worker's compensation, employer's liability laws or the Pennsylvania Motor Vehicle Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
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