DOMINION®
DDS
DENTAL
Services, Inc.

Dental disease is preventable. Dominion plans encourage the early detection of dental problems and routine maintenance. We help you take better care of your teeth and now it can cost you less to do it.

Dominion gives you the choice of three different dental options - choose the one that's right for you and your family.

Choose our Select Plan (same as a DHMO)[1] or Discount Program[2] and use a pre-qualified network dentist, or choose one of our three Access PPO Plans, which allow you to visit any licensed dentist. Dominion also offers a vision plan[3] with access to a leading provider network.

When you enroll, membership ID cards and detailed benefit information will be mailed to your home address. The dental benefits you've been waiting for are now available!

We Work For Your Benefit.®

Dominion Dental Services (Dominion) is a leading administrator of dental and vision[3] benefits in the Mid-Atlantic.[4] Among our nearly 600,000 customers are leading health plans, employer groups, municipalities, associations and individuals.

In the event of ambiguity, or conflict between this summary and the Description of Benefits and Member Copayments or Access PPO Coverage Schedule (whichever is applicable), the Description of Benefits and Member Copayments or Access PPO Coverage Schedule shall control.

1 Same as a DHMO with fixed member copayments, no annual maximum dollar limits, no waiting periods, no deductibles, no pre-authorization paperwork or pre-treatment estimates and no claim forms (except in the case of out-of-area emergencies).

2 This not an insurance plan. It is a reduced fee-for-service program designed specifically for individuals. Members pay a predetermined reduced fee for listed services provided by contracted providers. Dominion does not pay providers for services provided by contracted providers.

3 Vision plans are underwritten by Avalon Insurance Company (a Dominion affiliate) and are marketed and administered by Dominion Dental Services USA, Inc.

4 Includes DC, Delaware, Maryland, Pennsylvania and Virginia.

Three Unique Dental Programs to Choose From!

Discount Program 7000x[1]

Discount Program 7000x provides access to substantial discounts on most dental procedures. To receive the discounts you must obtain services from a general dentist from our Discount dental network, who will provide services and charge you according to a discounted fee schedule. If specialty care is required, your general dentist will refer you to a participating specialist who will provide care at a 25% discount.

You will pay only the discounted member fees directly to your dentist at the time of service. There are no claim forms, waiting periods, maximum limits, pre-authorization requirements or deductibles. Access to discounts for over 250 procedures is included. The complete list of discounted procedures and member fees will be mailed to you with your membership card. A summary of the procedures and member fees is included in this brochure.

Discount Program Services Include:[2]

No charge for routine annual cleanings
No charge for oral examinations
No charge for topical fluoride for children

These "no-charge" procedures account for over 35% of dental services most frequently performed for adults and almost 60% of the most frequently performed services for children.[3]

Receive more extensive care (fillings, dentures, crowns, root canals, periodontal care, oral surgery, etc.) at fees 35% to 60% lower than usual and customary charges (please see the Plan Comparison chart).

Discounted fees available for adult and child orthodontia!

*Please note the Discount Program is not a pediatric dental essential health benefit offered by a stand-alone dental plan under the Affordable Care Act. If you are interested in pediatric dental essential health benefit coverage, please consider the Select Plan Premium or the Access PPO options.

Select Plan Premium[4]

Select Plan Premium offers great value and extended coverage for your premium dollar. You must choose a general dentist from our Select Plan dental network. Your general dentist will provide services and charge you according to the Description of Benefits and Member Copayments. If specialty care is required, your general dentist will refer you to a participating specialist who will provide care at a 25% discount.

You will pay any copayments due under the Select Plan directly to your plan dentist at the time of service. There are no waiting periods, maximum limits, pre-authorization requirements or deductibles. Over 250 procedures are covered. The complete list of covered procedures will be mailed to you with your membership card. A summary of covered procedures and copayments is included in this brochure.

Select Plan Premium Benefits Include:

No charge for routine semiannual cleanings
No charge for oral examinations
No charge for bitewing X-rays

These "no-charge" procedures account for over 65% of dental services most frequently performed for adults.[3]

You will receive more extensive care (fillings, dentures, crowns, root canals, periodontal care, oral surgery, etc.) at fees 55% to 75% lower than usual and customary charges (please see the Plan Comparison chart).

Orthodontia is also covered!

Access PPO - 3 Different Plan Options

Access PPO is designed to provide members with maximum access to dentists. Members may seek dental services from any licensed dentist or use a participating Access PPO network dentist for greater coverage.

When dental care is received and expenses incurred, payments will be made in accordance with the list of benefits and services in the Coverage Schedule that will be mailed to you with your membership card. A summary of the plans' benefits can be found in the Plan Comparison in this brochure.

In-Network Access PPO Benefits Include:

No charge for routine semiannual cleanings
No charge for oral examinations
No charge for bitewing X-rays

These "no-charge" procedures account for over 65% of dental services most frequently performed for adults.[3]

We offer plan options that cover more extensive care (fillings, dentures, crowns, root canals, periodontal care, oral surgery, etc.). Please see the Access PPO Plan Comparison chart for full coverage details on the plan options.

Please look closely at the annual deductibles and maximum benefits on the Plan Comparison chart as they vary between plans. There are no waiting periods under the Access PPO plans.

Effective January 1, 2014, most Americans must obtain pediatric dental coverage for dependents under the age of 19 that complies with the EHB provisions under the Patient Protection and Affordable Care Act (PPACA). If you do not have this coverage through your health insurance plan, you may enroll your dependent(s) in Dominion's pediatric dental plan to ensure that you are meeting the requirements of PPACA. If you choose to enroll in the Select Plan Premium or Access PPO, your dependents under the age of 19 will automatically be enrolled in the pediatric dental plan (The Discount 7000x provides discounted fees for children; however it does not include an EHB compliant pediatric plan). Please see the Plan Comparison chart for pediatric coverage details for the Select Plan Premium and Access PPO plans.

For full coverage details regarding Dominion's certified pediatric dental plans, please visit DominionDental.com/pediatric.

1 This is not an insurance plan. It is a reduced fee-for-service program designed specifically for individuals. Members pay a predetermined reduced fee for listed services provided by contracted providers. Dominion does not pay providers for services provided by contracted providers.
2 There is a $15 office visit copayment. You must use a participating dentist to receive access to discounted procedures.
3 Dental Services, Inc. - based on annual review of utilization data.
4 Same as a DHMO with fixed member copayments, no annual maximum dollar limits, no waiting periods, no deductibles and no pre-authorization paperwork or pre-treatment estimates.

Plan Comparison - *Adults* (Age 19 & Over)

	Discount Program[1]	Select Plan Premium[1]	Access PPO Basic						Access PPO Plus		Access PPO Premium	
Procedures and Covered Services			In-Network			Out-of-Network			In-Network	Out-of-Network	In-Network	Out-of-Network
			Year 1[2]	Year 2[2]	Year 3[2]	Year 1[2]	Year 2[2]	Year 3[2]				
Diagnostic and Preventive Care	**45-100%**	**100%**	**100%**	**100%**	**100%**	**90%**	**90%**	**90%**	**100%**	**90%**	**100%**	**90%**
Oral exams	100%	100%	100%	100%	100%	90%	90%	90%	100%	90%	100%	90%
Bitewing X-Rays	45%	100%	100%	100%	100%	90%	90%	90%	100%	90%	100%	90%
Teeth cleanings (amount per year)	100% (1)	100% (2)	100% (2)	100% (2)	100% (2)	90% (2)	90% (2)	90% (2)	100% (2)	90% (2)	100% (2)	90% (2)
Basic Care	**45-50%**	**70-80%**	**50%**	**60%**	**80%**	**30%**	**50%**	**70%**	**50%**	**40%**	**80%**	**70%**
Full and panoramic X-rays	45%	80%	50%	60%	80%	30%	50%	70%	100% (Class I)	90% (Class I)	100% (Class I)	90% (Class I)
Fillings												
Amalgam (silver)	50%	80%	50%	60%	80%	30%	50%	70%	50%	40%	80%	70%
Composite (white)	50%	70%	50%	60%	80%	30%	50%	70%	50%	40%	80%	70%
Extraction, erupted tooth	50%	70%	50%	60%	80%	30%	50%	70%	50%	40%	80%	70%
Major Restorative Care	**35-60%**	**55-70%**	**15%**	**25%**	**50%**	**10%**	**20%**	**40%**	**0%**	**0%**	**50%**	**40%**
Prosthetics												
Crowns and bridges	45%	60%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%
Dentures	45%	70%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%
Relining of dentures	35%	60%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%
Periodontics (root planing and therapy)	50%	55%	15%	25%	50%	10%	20%	40%	50% (Class II)	40% (Class II)	50%	40%
Endodontics (root canals)	60%	70%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%
Oral Surgery (extraction of impacted teeth)	40%	55%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%
Orthodontics (adults)	**45%**	**45%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Benefit Features												
Office Visit	$15	$10	None						None		None	
Deductibles	None	None	$50 per adult (adult max $150)[3]						$50 per adult (adult max $150)[3]		$50 per adult (adult max $150)[4]	
Annual Maximums	None	None	$1,000 per insured person						$750 per insured person		$1,500 per insured person	
Waiting Periods	None	None	None						None		Yes[5]	
Receive Care From	Discount Network Dentist	Select Plan Network Dentist	Access PPO network dentist or any licensed dentist						Access PPO network dentist or any licensed dentist		Access PPO network dentist or any licensed dentist	

In the event of ambiguity, or conflict between this summary and the Description of Benefits and Member Copayments or Access PPO Coverage Schedule (whichever is applicable), the Description of Benefits and Member Copayments or Access PPO Coverage Schedule shall control.

1 Approximate percentage of coverage for the Select Plan is based on the Captiva Context Fee Schedule's 80th percentile for zip codes beginning with 223. Coverage may vary by state. A specific fee schedule applies and will be mailed with your membership card. Please see the Summary of Member Fees (Discount) or the Description of Member Copayments (Select Plan Premium) inside the brochure for a sample of member fees. To view copay schedules for the pediatric plans, please go to DominionDental.com/pediatric.

2 Year 1 benefits apply during the subscriber's first 12 months of continuous coverage. Year 2 benefits apply during the subscriber's second 12 months of continuous coverage. Year 3 benefits apply during the subscriber's third 12 months of continuous coverage.

3 Deductibles apply to all services.

4 Deductibles apply to basic care and major restorative care.

5 There are no waiting periods for diagnostic and preventive care. To be eligible for basic care, you must have completed 6 (six) months of continuous coverage. To be eligible for major restorative care, you must have completed 12 (twelve) months of continuous coverage. Waiting period credit will be given for the length of time an insured was covered under each benefit classification under the current employer's prior dental coverage.

Plan Comparison - *Kids* (Under Age 19)

	Select Plan Premium *Kids*[1]	Access PPO Premium *Kids*	
Procedures and Covered Services		**In-Network**	**Out-of-Network**
Diagnostic and Preventive Care	**100%**	**100%**	**80%**
Oral exams	100%	100%	80%
Bitewing X-Rays	100%	100%	80%
Full and panoramic X-rays	100%	100%	80%
Semiannual teeth cleanings	100%	100%	80%
Topical fluoride for children	100%	100%	80%
Basic Care	**75-85%**	**80%**	**60%**
Fillings			
Amalgam (silver)	85%	80%	60%
Composite (white)	80%	80%	60%
Extraction, erupted tooth	75%	80%	60%
Major Restorative Care	**75-80%**[2]	**50%**	**30%**
Prosthetics			
Crowns	75%	50%	30%
Bridges	75%	50%	30%
Dentures	75%	50%	30%
Periodontics (root planing and therapy)	75%	50%	30%
Endodontics (root canals)	80%	50%	30%
Oral Surgery (extraction of impacted teeth)	75%	50%	30%
Implants*	60%	50%	30%
Medically-Necessary Orthodontics (child) (2- year waiting period)	**30%**	**50%**	**0-30%** 0% (DC, DE, PA, VA) 30% (MD)
Discounted non-medically necessary orthodontics	Yes	N/A	N/A
Benefit Features			
Office Visit	None	None	None
Deductibles	None	$50 per child ($100 max)[3]	$50 per child ($100 max)[3]
Out-of-Pocket Maximums	$350[4]	$350[4]	N/A
Waiting Periods	None[5]	None[5]	None[5]
Receive Care From	Select Plan Network DentistNetwork	Access PPO network dentist or any licensed dentist	Access PPO network dentist or any licensed dentist

* Implants are covered on Access PPO *Kids* and Select Plan *Kids* plans in the District of Columbia and Pennsylvania only. Delaware, Maryland and Virginia do not have implant coverage.

In the event of ambiguity, or conflict between this summary and the Description of Benefits and Member Copayments or Access PPO Premium *Kids* Coverage Schedule (whichever is applicable), the Description of Benefits and Member Copayments or Access PPO Premium *Kids* Coverage Schedule shall control.

1 Approximate percentage of coverage for the Select Plan is based on the Captiva Context Fee Schedule's 80th percentile for zip codes beginning with 232. Coverage may vary by state. A specific fee schedule applies and will be mailed with your membership card. Please see the Summary of Member Fees (Discount) or the Description of Member Copayments (Select Plan Premium) inside the brochure for a sample of member fees. To view copay schedules for the pediatric plans, please go to DominionDental.com/pediatric.

2 Specialty care is provided at the listed copayment whether performed by a participating general dentist or a participating specialist.

3 Deductible is combined for all covered services for each calendar year per pediatric member - maximum $200 for pediatric members. Deductibles are waived for Diagnostic and Preventive Care (Class I) and Orthodontia (Class IV) when in-network; and

4 The $350 annual out-of-pocket maximum applies to a single child. There is a $700 annual out-of-pocket maximum for two or more children.

5 Applies to District of Columbia, Delaware, Maryland and Pennsylvania. There is a 24-month waiting period for medically necessary orthodontic benefits. Virginia has no waiting periods.

Monthly Rates - Effective 1/1/16-12/1/16

Discount Program	
Member	7.50
Member + 1 or More	10.00

Rates are valid through December 2016. Members who make monthly premium payments will receive a notice if there is a change to the plan rates or covered benefits prior to January 2017. Members who make annual premium payments will receive a renewal notice prior to January 2017.

ACCESS PPO PREMIUM PER ADULT [Age]	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Access PPO Basic [19-29]	17.67	19.85	15.88	17.37	15.40	15.14	15.76	14.35	17.81	18.16	17.56	15.55	17.16	18.78	20.40	22.02	23.63	25.25	26.87	28.49
Access PPO Basic [30-45]	20.72	23.28	18.62	20.36	18.06	17.75	18.49	16.83	20.89	21.29	20.59	18.23	20.13	22.03	23.92	25.82	27.72	29.61	31.51	33.42
Access PPO Basic [46+]	24.88	27.95	22.36	24.45	21.69	21.32	22.20	20.21	25.08	25.57	24.72	21.89	24.17	26.45	28.73	31.00	33.28	35.56	37.84	40.12
Access PPO Plus [19-29]	15.21	17.02	13.72	14.96	13.33	13.13	13.64	12.48	15.36	15.64	15.15	13.61	15.12	16.63	18.13	19.63	21.14	22.65	24.15	25.66
Access PPO Plus [30-45]	17.84	19.96	16.09	17.54	15.63	15.40	16.00	14.64	18.01	18.34	17.76	15.96	17.74	19.50	21.27	23.02	24.79	26.56	28.33	30.09
Access PPO Plus [46+]	21.42	23.97	19.32	21.06	18.77	18.49	19.21	17.58	21.62	22.02	21.33	19.17	21.30	23.42	25.54	27.64	29.76	31.89	34.01	36.13
Access PPO Premium [19-29]	20.40	22.96	18.26	20.03	17.69	17.37	18.12	16.44	20.54	20.94	20.23	17.69	19.42	21.17	22.92	24.66	26.40	28.14	29.89	31.63
Access PPO Premium [30-45]	23.92	26.93	21.42	23.49	20.75	20.37	21.25	19.28	24.09	24.55	23.73	20.74	22.78	24.82	26.88	28.92	30.96	33.00	35.05	37.10
Access PPO Premium [46+]	28.73	32.33	25.72	28.21	24.92	24.46	25.51	23.15	28.93	29.48	28.49	24.90	27.35	29.81	32.28	34.72	37.18	39.63	42.09	44.54
ACCESS PPO PREMIUM PER CHILD (Under Age 19) [Max Charge of 3 per family]	22.95	25.95	20.95	22.95	19.95	18.95	19.95	17.95	22.95	23.95	22.95	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SELECT PLAN PREMIUM PER ADULT (Age)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Select Plan [19-29]	14.92	20.65	11.66	14.37	10.81	11.44	12.62	10.00	14.78	15.41	14.29	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Select Plan [30-45]	17.50	24.22	13.67	16.85	12.68	13.41	14.80	11.73	17.33	18.07	16.76	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Select Plan [46+]	21.01	29.08	16.41	20.23	15.22	16.11	17.77	14.08	20.81	21.70	20.12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SELECT PLAN PREMIUM PER CHILD (Under Age 19) [Max Charge of 3 per family]	17.95	23.95	14.95	16.95	14.95	13.95	14.95	13.95	20.95	20.95	19.95	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

How to Calculate Your Monthly Rates

1. Determine your rating region based on your county or state of residence. See Region Legend on page 6.
2. Locate your monthly premium in the chart by referencing the rating region, your plan choice and your age band (range). This is your monthly rate if you are the only subscriber.
3. For each dependent, repeat step 2. (You will only be charged for up to three child dependents).
4. Add up each family member's rate to determine your total monthly premium.

Example: A family of four living in Alexandria, VA, with two adults in the 30-45 age band and two children under age 19 enrolling in the Access PPO Basic plan:

1. Alexandria, VA is in Region 10.
2. Access PPO Basic monthly rate in Region 10 in the 30-45 age band = $21.29.
3. Primary Subscriber (Adult 1) and Adult Dependent (Adult 2) = (2 x $21.29 = $42.58)
   Dependent Child 1 and Dependent Child 2 = (2 x $23.95 = $47.90)
4. $42.58 + $47.90 = $90.48

Rating Regions

Region Legend	
Region 1	DC
Region 2	DE
Region 3	MD counties: Anne Arundel, Baltimore City, Baltimore, Harford, Howard
Region 4	MD counties: Montgomery, Prince George's
Region 5	MD counties: Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, Worcester
Region 6	PA counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, York *Individuals in Region 6 are located in the operating territory of Dominion's parent company. Please visit TeethkeepersPA.com to enroll*
Region 7	PA counties: Bucks, Chester, Delaware, Montgomery, Philadelphia
Region 8	PA counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Clarion, Clearfield, Clinton, Crawford, Elk, Erie, Fayette, Forrest, Greene, Huntingdon, Indiana, Jefferson, Lackawanna, Lawrence, Luzerne, Lycoming, McKean, Mercer, Monroe, Pike, Potter, Somerset, Sullivan, Susquehanna, Venango, Warren*, Washington, Wayne, Westmoreland, Wyoming
Region 9	VA counties: Amelia, Caroline, Charles City, Chesterfield, Colonial Heights City,* Cumberland*, Dinwiddie, Goochland, Hanover, Henrico, Hopewell City*, King and Queen, King William, Louisa, New Kent, Petersburg City, Powhatan, Prince George, Richmond City, Sussex*
Region10	VA counties: Alexandria City, Arlington, Chesapeake City, Clarke, Fairfax, Fairfax City, Falls Church City, Fauquier, Fredericksburg City, Gloucester, Hampton City, Isle of Wight, James City, Loudoun, Manassas City, Manassas Park City, Mathews, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Prince William, Spotsylvania, Stafford, Suffolk City, Surry, Virginia Beach City, Warren, Williamsburg City, York
Region 11	VA counties: Accomack*, Albemarle*, Amherst*, Augusta*, Bedford*, Bedford City*, Bland*, Botetourt*, Bristol City*, Buckingham*, Campbell*, Carroll*, Charlottesville City*, Craig*, Culpeper, Danville City*, Emporia City*, Essex, Floyd*, Fluvanna*, Franklin*, Franklin City*, Frederick*, Greene*, Greensville*, Harrisonburg City*, Henry*, Highland*, King George, Lancaster*, Lynchburg City*, Madison, Martinsville City*, Middlesex*, Montgomery*, Nelson*, Northampton, Nothumberland*, Nottoway*, Orange, Page, Patrick*, Pittsylvania*, Prince Edward*, Pulaski*, Rappahannock, Richmond*, Roanoke*, Roanoke City*, Rockbridge*, Rockingham*, Russell*, Salem City*, Scott*, Shenandoah*, Smyth*, Southampton*, Staunton City*, Washington*, Waynesboro City*, Westmoreland*, Winchester City, Wise*
Region 12	OK*, WV*
Region 13	KY*, NE*, OH*, UT*
Region 14	AL*, IN*, MT*, TN*
Region 15	AR*, AZ*, FL*, GA*, IA*, IL*, KS*, MI*, MO*, MS*, ND*, NM*, RI*, SD*, TX*
Region 16	ID*, LA*, NH*, NV*, NY*, SC*
Region 17	CA*, HI*, NJ*, VT*, WY*
Region 18	CO*, CT*, MA*, ME*, WI*
Region 19	OR*, WA*
Region 20	AK*, MN*, NC*

* Select Plan is not available in the states or counties with an asterisk (*).
Pediatric plans are available in DC, DE, PA & VA only.

Discount Program 70000x

Description of Services & Member Fees

ADA CODE	SERVICE	MEMBER FEE ($)
DIAGNOSTIC/PREVENTIVE		
D9439	Office visit	15
D0120	Periodic oral eval - established patient	0
D0140	Limited oral eval - problem focused	0
D0145	Oral eval for a patient under 3 years of age	0
D0150	Comprehensive oral eval - new or established patient	0
D0160	Detailed and extensive oral eval - problem focused	67
D0170	Re-evaluation - limited, problem focused	0
D0210	Intraoral - complete series (including bitewings)	66
D0220	Intraoral - periapical first film	14
D0230	Intraoral - periapical each add. film	12
D0240	Intraoral - occlusal film	0
D0250/60	Extraoral - first film and each add. Film	0
D0270	Bitewing - single film	14
D0272	Bitewings - two films	22
D0273	Bitewings - three films	27
D0274	Bitewings - four films	31
D0277	Vertical bitewings - 7 to 8 films	48
D0330	Panoramic film	59
D0340	Cephalometric Film	0
D0350	Oral/facial photographic images	0
D0460	Pulp vitality tests	30
D0470	Diagnostic casts	0
D1110	Prophylaxis (cleaning) - adult	0
D1110*	Additional cleaning (expecting mothers or Diabetics)	40
D1120	Prophylaxis (cleaning) - child	0
D1203	Topical application of fluoride - child	0
D1204	Topical application of fluoride - adult	0
D1206	Topical fluoride varnish for mod/high risk caries patients	0
D1310	Nutritional counseling for control of dental disease	0
D1320/30	Oral hygiene instructions	0
D1351	Sealant - per tooth	28
D1352	Prev resin rest. mod/high caries risk – perm. tooth	28
	SPACE MAINTAINERS	
D1510/20	Space maintainer - fixed/removable - unilateral	176
D1515/25	Space maintainer - fixed/removable - bilateral	250
D1550	Re-cementation of space maintainer	44
RESTORATIVE DENTISTRY (FILLINGS)		
	AMALGAM RESTORATIONS (SILVER)	
D2140	Amalgam - one surface, prim. or perm.	70
D2150	Amalgam - two surfaces, prim. or perm.	90
D2160	Amalgam - three surfaces, prim. or perm.	107
D2161	Amalgam - >=4 surfaces, prim. or perm.	128
	RESIN/COMPOSITE RESTORATIONS (TOOTH COLORED)	
D2330	Resin-based composite - one surface, anterior	80
D2331	Resin-based composite - two surfaces, anterior	101
D2332	Resin-based composite - three surfaces, anterior	124
D2335	Resin-based composite - >=4 surfaces, anterior	157
D2391	Resin-based composite - one surface, posterior	90
D2392	Resin-based composite - two surfaces, posterior	118
D2393	Resin-based composite - three surfaces, posterior	149
D2394	Resin-based composite - >=4 surfaces, posterior	174
D2940	Sedative filling	60
D2951	Pin retention - per tooth, in addition to restoration	36
D3110/20	Pulp cap - direct/indirect (excl. final restoration)	47
CROWN & BRIDGE♦		
D2390	Resin-based composite crown, anterior	245
D2510	Inlay - metallic - one surface	472
D2520	Inlay - metallic - two surfaces	502
D2530	Inlay - metallic - three or more surfaces	518
D2542	Onlay - metallic-two surfaces	541
D2543	Onlay - metallic-three surfaces	575
D2544	Onlay - metallic-four or more surfaces	575
D2610	Inlay - porcelain/ceramic - one surface	492
D2620	Inlay - porcelain/ceramic - two surfaces	522
D2630	Inlay - porcelain/ceramic - >=3 surfaces	551
D2642	Onlay - porcelain/ceramic - two surfaces	565
D2643	Onlay - porcelain/ceramic - three surfaces	593
D2644	Onlay - porcelain/ceramic - >=4 surfaces	593
D2650	Inlay - resin-based composite - one surface	427
D2651	Inlay - resin-based composite - two surfaces	479
D2652	Inlay - resin-based composite - >=3 surfaces	528
D2662	Onlay - resin-based composite - two surfaces	555
D2663	Onlay - resin-based composite - three surfaces	577
D2664	Onlay - resin-based composite - >=4 surfaces	577

ADA CODE	SERVICE	MEMBER FEE ($)
D2710	Crown - resin based composite (indirect)	375
D2712	Crown - 3/4 resin-based composite (indirect)	589
D2720/21/22	Crown - resin with metal	619
D2740	Crown - porcelain/ceramic substrate	714
D2750/51/52	Crown - porcelain fused metal	677
D2780/81/82	Crown - 3/4 cast with metal	539
D2783	Crown - 3/4 porcelain/ceramic	614
D2790/91/92	Crown - full cast metal	611
D2910/20	Recement inlay, onlay/crown or partial coverage rest.	61
D2930	Prefab. stainless steel crown - prim. tooth	159
D2931	Prefab. stainless steel crown - perm. tooth	168
D2932	Prefabricated resin crown	185
D2950	Core buildup, including any pins	167
D2952	Cast post and core in addition to crown	233
D2954	Prefab. post and core in addition to crown	183
D2955	Post removal (not in conj. with endo. therapy)	149
D2970	Temporary crown (fractured tooth)	0
D2980	Crown repair, by report	127
PROSTHETICS (DENTURES)		
D5110/20	Complete denture - maxillary/mandibular	895
D5130/40	Immediate denture - maxillary/mandibular	963
D5211/12	Maxillary/mandibular partial denture - resin base	692
D5213/14	Maxillary/mandibular partial denture - cast metal	960
D5225/25	Maxillary/mandibular partial denture - flexible base	960
D5281	Rem. unilateral partial denture - one piece cast metal	540
D5410/11	Adjust complete denture - maxillary/mandibular	51
D5421/22	Adjust partial denture - maxillary/mandibular	51
D5510/5610	Repair broken denture base (complete/resin)	113
D5520	Replace missing or broken teeth - complete denture	99
D5620	Repair cast framework	164
D5630	Repair or replace broken clasp	149
D5640	Replace broken teeth - per tooth	101
D5650	Add tooth to existing partial denture	127
D5660	Add clasp to existing partial denture	158
D5670/71	Replace all teeth and acrylic on cast metal framework	358
D5710/11	Rebase complete maxillary/mandibular denture	334
D5720/21	Rebase maxillary/mandibular partial denture	328
D5730/31	Reline complete maxillary/mandibular denture (chairside)	212
D5740/41	Reline maxillary/mandibular partial denture (chairside)	212
D5750/51	Reline complete maxillary/mandibular denture (lab)	275
D5760/61	Reline maxillary/mandibular partial denture (lab)	271
D5810/11	Interim complete denture - maxillary/mandibular	449
D5820/21	Interim partial denture - maxillary/mandibular	383
D5850/51	Tissue conditioning - maxillary/mandibular	107
BRIDGE/PONTICS♦		
D6000-D6199	ALL IMPLANT SERVICES - 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants)	
D6210/11/12	Pontic - metal	611
D6240/41/42	Pontic - porcelain fused metal	677
D6245	Pontic - porc./ceramic	714
D6250/51/52	Pontic - resin with metal	619
D6545	Retainer - cast metal for resin bonded fixed prosthesis	304
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	477
D6600	Inlay - porc./ceramic, two surfaces	522
D6601	Inlay - porc./ceramic, >=3 surfaces	551
D6602	Inlay - cast high noble metal, two surfaces	502
D6603	Inlay - cast high noble metal, >=3 surfaces	518
D6604	Inlay - cast predominantly base metal, two surfaces	502
D6605	Inlay - cast predominantly base metal, >=3 surfaces	518
D6606	Inlay - cast noble metal, two surfaces	502
D6607	Inlay - cast noble metal, >=3 surfaces	518
D6608	Onlay -porc./ceramic, two surfaces	565
D6609	Onlay - porc./ceramic, three or more surfaces	593
D6610	Onlay - cast high noble metal, two surfaces	541
D6611	Onlay - cast high noble metal, >=3 surfaces	575
D6612	Onlay - cast predominantly base metal, two surfaces	541
D6613	Onlay - cast predominantly base metal, >=3 surfaces	575
D6614	Onlay - cast noble metal, two surfaces	541
D6615	Onlay - cast noble metal, >=3 surfaces	575
D6720/21/22	Crown - resin with metal	619
D6740	Crown - porc./ceramic	714
D6750/51/52	Crown - porcelain fused metal	677
D6780	Crown - 3/4 cast high noble metal	539
D6781	Crown - 3/4 cast predominantly base metal	539
D6782	Crown - 3/4 cast noble metal	539
D6783	Crown - 3/4 porc./ceramic	614
D6790/91/92	Crown - full cast metal	611

♦All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

Discount Program 70oox

ADA CODE	SERVICE	MEMBER FEE ($)
D6930	Recement fixed partial denture	86
D6970	Post and core in addition to fixed part. dent. ret.	238
D6972	Prefab post and core in addition to fixed part. dent. ret.	203
D6973	Core build up for retainer, including any pins	151
D6975	Coping - metal	389
D6976	Each add. indirectly fabricated post - same tooth	155
D6977	Each add. prefab post - same tooth	72
D6980	Fixed partial denture repair, by report	206
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain	64
D9210/15	Local anesthesia	0
D9211	Regional block anesthesia	0
D9212	Trigeminal division block anesthesia	0
D9220	Deep sedation/general anesthesia - first 30 min.	205
D9221	Deep sedation/general anesthesia - each add. 15 min.	103
D9241	Intravenous conscious sedation/analgesia - first 30 min.	205
D9242	IV conscious sedation/analgesia - each add. 15 min.	103
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	35
D9310	Consultation (diagnostic service by nontreating dentist)	63
D9910	Application of desensitizing medicament	31
D9930	Treatment of complications (post-surgical)	48
D9990	Broken office appointment	50
ENDODONTICS[1]		
D3220	Therapeutic pulpotomy (excl. final restor.)	112
D3221	Pulpal debridement, prim. and perm. teeth	112
D3310	Endodontic therapy, anterior tooth	413
D3320	Endodontic therapy, bicuspid tooth	494
D3330	Endodontic therapy, molar	606
D3333	Internal root repair of perforation defects	126
D3346	Retreat of prev. root canal therapy, anterior	453
D3347	Retreat of prev. root canal therapy, bicuspid	538
D3348	Retreat of prev. root canal therapy, molar	653
D3410	Apicoectomy/periradicular surgery, anterior	377
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	424
D3425	Apicoectomy/periradicular surgery, molar (first root)	498
D3426	Apicoectomy/periradicular surgery (each add. root)	189
D3430	Retrograde filling - per root	143
D3450	Root amputation - per root	270
D3920	Hemisection, not inc. root canal therapy	256
D3950	Canal prep/fitting of preformed dowel or post	143
PERIODONTICS[1]		
D0180	Comp. periodontal eval - new or established patient	36
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	369
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	124
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	438
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	131
D4260	Osseous surgery - >3 cont. teeth, per quad	616
D4261	Osseous surgery - <=3 cont. teeth, per quad	491
D4268	Surgical revision proc., per tooth	448
D4274	Distal or proximal wedge procedure	393
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	138
D4342	Perio scaling and root planing - <= 3 teeth, per quad	78
D4355	Full mouth debridement	106
D4381	Localized delivery of chemotherapeutic agents	123
D4910	Periodontal maintenance	83
D9940	Occlusal guard, by report	328
D9950	Occlusion analysis - mounted case	169
D9951	Occlusal adjustment - limited	86
D9952	Occlusal adjustment - complete	361
ORAL SURGERY[1]		
D7111	Extraction, coronal remnants - deciduous tooth	82
D7140	Extraction, erupted tooth or exposed root	85
D7210	Surgical rem. of erupted tooth req. bone cut	167
D7220	Removal of impacted tooth - soft tissue	196
D7230	Removal of impacted tooth - partially bony	255
D7240	Removal of impacted tooth - completely bony	311
D7241	Removal of imp. tooth - completely bony, with unusual surg. complications	364
D7250	Surgical removal of residual tooth roots	181
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	315
D7280	Surgical access of an unerupted tooth	285
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	159
D7310	Alveoloplasty, in conj. with ext. - 4 or more teeth, per quad	175
D7320	Alveoloplasty not in conj. with extractions - 4 or more teeth, per quad	258
D7510	Incision and drainage of abscess - intraoral soft tissue	137
D7960	Frenulectomy (frenectomy or frenotomy) - separate proc.	269

[1]As performed by a participating General Dentist. See Plan Exclusion # 13.

ADA CODE	SERVICE	MEMBER FEE ($)
ORTHODONTICS[2]		
D8660	Pre-orthodontic treatment visit	413
D8070	Comp. ortho. treatment - transitional dentition	3304
D8080	Comp. ortho. treatment - adolescent dentition	3422
D8090	Comp. ortho. treatment - adult dentition	3658
D8670	Periodic ortho. treatment visit (as part of contract)	118
D8680	Orthodontic retention (rem. of appl. and placement of retainer(s))	413

[2] Phase I Treatment (D8010 - D8050) is provided at a 15% reduction from the orthodontist's UCR fees. See exclusion #15 for additional coverage exclusions.

Program Exclusions

1. Services which are covered under Medicare, worker's compensation, employer's liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law (Pennsylvania policyholders only).
2. Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Participating Dentist, such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as covered benefits under this Program.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorizedby such office or Dominion Dental Services USA, Inc. (with the exception of out-of-area emergency dental services).
12. Services related to the treatment of TMD (Temporomandibular Disorder).
13. Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating General Dentist. Above copayments do not apply when performed by a Participating Specialist (with the exception of orthodontics). Participating Specialists, if available, have entered into an agreement with Dominion Dental Services to provide dental services to members at a 25% reduction from their Usual, Customary, and Reasonable (UCR) fees. In Delaware, Participating Specialists will provide a reduction from their UCR that will vary between specialists.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.

Program Limitations

1. Two (2) evaluations are covered per calendar year including a maximum of one (1) comprehensive evaluation.
2. One (1) problem focused exam is covered per calendar year.
3. One (1) teeth cleaning (prophylaxis) is covered per calendar year.
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) bitewing x-rays are covered per calendar year.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
7. One (1) sealant or preventative resin restoration per tooth is covered per lifetime, up to age 16 (limited to permanent 1st and 2nd molars).
8. Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment program. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
11. Relining and rebasing of dentures is covered once every 24 months.
12. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
13. Root planing or scaling is covered once every 24 months per quadrant.
14. Full mouth debridement is covered once per lifetime.
15. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater.
16. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
17. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

Select Plan Premium

Description of Benefits & Member Copayments for Adult Services (age 19 and over)

ADA CODE	BENEFIT	MEMBER COPAYMENT(S)
DIAGNOSTIC/PREVENTIVE		
D9439	Office visit	10
D0120	Periodic oral eval - established patient	0
D0140	Limited oral eval - problem focused	0
D0150	Comprehensive oral eval - new or established patient	0
D0160	Detailed and extensive oral eval - problem focused	0
D0170	Re-evaluation - limited, problem focused	0
D0210	Intraoral - complete series (including bitewings)	26
D0220	Intraoral - periapical first film	0
D0230	Intraoral - periapical each add. film	0
D0240	Intraoral - occlusal film	0
D0250/60	Extraoral - first film and each add. film	0
D0270-14	Bitewing x-rays - 1 to 4 films	0
D0277	Vertical bitewings - 7 to 8 films	0
D0330	Panoramic film	30
D0340	Cephalometric Film	0
D0350	Oral/facial photographic images	0
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
D1110	Prophylaxis (cleaning) - adult	0
D1110*	Additional cleaning (expecting mothers or Diabetics)	40
D1204	Topical application of fluoride - adult	0
D1206	Topical fluoride varnish for mod/high risk caries patients	0
D1310	Nutritional counseling for control of dental disease	0
D1320/30	Oral hygiene instructions	0
RESORATIVE DENTISTRY (FILLINGS)		
	AMALGAM RESTORATIONS (SILVER)	
D2140	Amalgam - one surface	37
D2150	Amalgam - two surfaces	46
D2160	Amalgam - three surfaces	58
D2161	Amalgam - >=4 surfaces	69
	RESIN/COMPOSITE RESTORATIONS (TOOTH COLORED)	
D2330	Resin-based composite - one surface, anterior	64
D2331	Resin-based composite - two surfaces, anterior	76
D2332	Resin-based composite - three surfaces, anterior	90
D2335	Resin-based composite - >=4 surfaces, anterior	109
D2391	Resin-based composite - one surface, posterior	68
D2392	Resin-based composite - two surfaces, posterior	80
D2393	Resin-based composite - three surfaces, posterior	93
D2394	Resin-based composite - >=4 surfaces, posterior	112
D2940	Sedative filling	37
D2951	Pin retention - per tooth, in addition to restoration	22
D3110/20	Pulp cap - direct/indirect (excl. final restoration)	28
CROWN & BRIDGE♦		
D2390	Resin-based composite crown, anterior	175
D2510	Inlay - metallic - one surface	390
D2520	Inlay - metallic - two surfaces	390
D2530	Inlay - metallic - three or more surfaces	407
D2542	Onlay - metallic-two surfaces	423
D2543	Onlay - metallic-three surfaces	511
D2544	Onlay - metallic-four or more surfaces	511
D2610	Inlay - porcelain/ceramic - one surface	410
D2620	Inlay - porcelain/ceramic - two surfaces	410
D2630	Inlay - porcelain/ceramic - >=3 surfaces	427
D2642	Onlay - porcelain/ceramic - two surfaces	439
D2643	Onlay - porcelain/ceramic - three surfaces	459
D2644	Onlay - porcelain/ceramic - >=4 surfaces	459
D2650	Inlay - resin-based composite - one surface	425
D2651	Inlay - resin-based composite - two surfaces	425
D2652	Inlay - resin-based composite - >=3 surfaces	425
D2662	Onlay - resin-based composite - two surfaces	429
D2663	Onlay - resin-based composite - three surfaces	429
D2664	Onlay - resin-based composite - >=4 surfaces	429
D2710	Crown - resin based composite (indirect)	259
D2712	Crown - 3/4 resin-based composite (indirect)	450
D2720/21/22	Crown - resin with metal	470
D2740	Crown - porcelain/ceramic substrate	531
D2750/51/52	Crown - porcelain fused metal	495
D2780/81/82	Crown - 3/4 cast with metal	457
D2783	Crown - 3/4 porcelain/ceramic	469
D2790/91/92	Crown - full cast metal	481

ADA CODE	BENEFIT	MEMBER COPAYMENT(S)
D2910/20	Recement inlay, onlay/crown or partial coverage rest.	41
D2931	Prefab. stainless steel crown	119
D2932	Prefabricated resin crown	135
D2950	Core buildup, including any pins	120
D2952	Cast post and core in addition to crown	181
D2954	Prefab. post and core in addition to crown	148
D2955	Post removal (not in conj. with endo. therapy)	101
D2970	Temporary crown (fractured tooth)	0
D2980	Crown repair, by report	93
PROSTHETICS (DENTURES)		
D5110/20	Complete denture - maxillary/mandibular	664
D5130/40	Immediate denture - maxillary/mandibular	708
D5211/12	Maxillary/mandibular partial denture - resin base	613
D5213/14	Maxillary/mandibular partial denture - cast metal	722
D5225/26	Maxillary/mandibular partial denture - flexible base	722
D5281	Rem. unilateral partial denture - one piece cast metal	397
D5410/11	Adjust complete denture - maxillary/mandibular	35
D5421/22	Adjust partial denture - maxillary/mandibular	35
D5510/5610	Repair broken denture base (complete/resin)	84
D5520	Replace missing or broken teeth - complete denture	84
D5620	Repair cast framework	84
D5630/60	Clasp repaired, replaced or added	112
D5640	Replace broken teeth - per tooth	84
D5650	Add tooth to existing partial denture	84
D5660	Add clasp to existing partial denture	112
D5670/71	Replace all teeth and acrylic on cast metal framework	263
D5710/11	Rebase complete maxillary/mandibular denture	253
D5720/21	Rebase maxillary/mandibular partial denture	253
D5730/31	Reline complete maxillary/mandibular denture (chairside)	152
D5740/41	Reline maxillary/mandibular partial denture (chairside)	152
D5750/51	Reline complete maxillary/mandibular denture (lab)	214
D5760/61	Reline maxillary/mandibular partial denture (lab)	214
D5810/11	Interim complete denture - maxillary/mandibular	333
D5820/21	Interim partial denture - maxillary/mandibular	333
D5850/51	Tissue conditioning - maxillary/mandibular	75
BRIDGE & PONTICS♦		
D6000-D6199	ALL IMPLANT SERVICES - 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants)	
D6210/11/12	Pontic - metal	481
D6240/41/42	Pontic - porcelain fused metal	495
D6245	Pontic - porcelain/ceramic	531
D6250/51/52	Pontic - resin with metal	470
D6545	Retainer - cast metal for resin bonded fixed prosthesis	233
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	364
D6600	Inlay - porc./ceramic, two surfaces	410
D6601	Inlay - porc./ceramic, >=3 surfaces	427
D6602	Inlay - cast high noble metal, two surfaces	390
D6603	Inlay - cast high noble metal, >=3 surfaces	407
D6604	Inlay - cast predominantly base metal, two surfaces	390
D6605	Inlay - cast predominantly base metal, >=3 surfaces	407
D6606	Inlay - cast noble metal, two surfaces	390
D6607	Inlay - cast noble metal, >=3 surfaces	407
D6608	Onlay -porc./ceramic, two surfaces	439
D6609	Onlay - porc./ceramic, three or more surfaces	459
D6610	Onlay - cast high noble metal, two surfaces	423
D6611	Onlay - cast high noble metal, >=3 surfaces	511
D6612	Onlay - cast predominantly base metal, two surfaces	423
D6613	Onlay - cast predominantly base metal, >=3 surfaces	511
D6614	Onlay - cast noble metal, two surfaces	423
D6615	Onlay - cast noble metal, >=3 surfaces	511
D6720/21/22	Crown - resin with metal	470
D6740	Crown - porcelain/ceramic	531
D6750/51/52	Crown - porcelain fused metal	495
D6780	Crown - 3/4 cast high noble metal	457
D6781	Crown - 3/4 cast predominantly base metal	457
D6782	Crown - 3/4 cast noble metal	457
D6783	Crown - 3/4 porc./ceramic	469
D6790/91/92	Crown - full cast metal	481
D6930	Recement fixed partial denture	66
D6970	Post and core in addition to fixed part. dent. ret.	180
D6972	Prefab post and core in addition to fixed part. dent. ret.	148
D6973	Core build up for retainer, including any pins	119
D6975	Coping - metal	298

♦All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

Select Plan Premium

ADA CODE	BENEFIT	MEMBER COPAYMENT(S)
D6976	Each add. indirectly fabricated post - same tooth	119
D6977	Each add. prefab post - same tooth	55
D6980	Fixed partial denture repair, by report	157
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain	43
D9210/15	Local anesthesia	0
D9211	Regional block anesthesia	0
D9212	Trigeminal division block anesthesia	0
D9220	Deep sedation/general anesthesia - first 30 min	205
D9221	Deep sedation/general anesthesia - each add. 15 min	103
D9241	Intravenous conscious sedation/analgesia - first 30 min.	205
D9242	IV conscious sedation/analgesia - each add. 15 min.	103
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	37
D9310	Consultation (diagnostic service by nontreating dentist)	42
D9910	Application of desensitizing medicament	31
D9930	Treatment of complications (post-surgical)	43
D9990	Broken office appointment	50
ENDODONTICS[1]		
D3220	Therapeutic pulpotomy (excl. final restor.)	81
D3221	Pulpal debridement	87
D3310	Endodontic therapy, anterior tooth	325
D3320	Endodontic therapy, bicuspid tooth	395
D3330	Endodontic therapy, molar	488
D3333	Internal root repair of perforation defects	96
D3346	Retreat of prev. root canal therapy, anterior	356
D3347	Retreat of prev. root canal therapy, bicuspid	418
D3348	Retreat of prev. root canal therapy, molar	527
D3410	Apicoectomy/periradicular surgery, anterior	310
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	333
D3425	Apicoectomy/periradicular surgery, molar (first root)	379
D3426	Apicoectomy/periradicular surgery (each add. root)	148
D3430	Retrograde filling - per root	113
D3450	Root amputation - per root	202
D3920	Hemisection, not inc. root canal therapy	202
D3950	Canal prep/fitting of preformed dowel or post	125
PERIODONTICS[1]		
D0180	Comp. periodontal eval - new or established patient	36
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad	265
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad	94
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	324
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	90
D4260	Osseous surgery - >3 cont. teeth, per quad	485
D4261	Osseous surgery - <=3 cont. teeth, per quad	360
D4268	Surgical revision proc., per tooth	329
D4274	Distal or proximal wedge procedure	308
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	105
D4342	Perio scaling and root planing - <= 3 teeth, per quad	57
D4355	Full mouth debridement	77
D4381	Localized delivery of chemotherapeutic agents	90
D4910	Periodontal maintenance	66
D9940	Occlusal guard, by report	298
D9950	Occlusion analysis - mounted case	81
D9951	Occlusal adjustment - limited	62
D9952	Occlusal adjustment - complete	255
ORAL SURGERY[1]		
D7111	Extraction, coronal remnants - deciduous tooth	45
D7140	Extraction, erupted tooth or exposed root	63
D7210	Surgical rem. of erupted tooth req. bone cut	127
D7220	Removal of impacted tooth - soft tissue	144
D7230	Removal of impacted tooth - partially bony	189
D7240	Removal of impacted tooth - completely bony	227
D7241	Removal of imp. tooth - completely bony, with unusual surg. complications	181
D7250	Surgical removal of residual tooth roots	136
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	211
D7280	Surgical access of an unerupted tooth	111
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	41
D7310/20	Alveoloplasty, per quad	135
D7510	Incision and drainage of abscess - intraoral soft tissue	91
D7960	Frenulectomy (frenectomy/frenotomy) - separate proc.	256

[1] As performed by a Participating General Dentist. See Plan Exclusion #13.

ADA CODE	BENEFIT	MEMBER COPAYMENT(S)
ORTHODONTICS[2]		
D8090	Comp. ortho. treatment - adult dentition	3658
D8660	Pre-orthodontic treatment visit	413
D8670	Periodic ortho. treatment visit (as part of contract)	118
D8680	Orthodontic retention (rem. of appl. and placement of retainer(s))	413

[2] Phase I Treatment (D8010 - D8050) is provided at a 15% reduction from the orthodontist's UCR fees. See exclusion #15 for additional coverage exclusions

Plan Exclusions

1. Services which are covered under Medicare, worker's compensation, employer's liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as covered benefits under this Plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergency dental services).
12. Services related to the treatment of TMD (Temporomandibular Disorder).
13. Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating General Dentist. Above copayments do not apply when performed by a Participating Specialist (with the exception of orthodontics). Participating Specialists, if available, have entered into an agreement with the Plan to provide dental services to members at a 25% reduction from their Usual, Customary, and Reasonable (UCR) fees. This means that Member will be responsible for 25% of the lesser of a Participating Specialist's UCR fee; of the amount the provider has agreed to accept. Members must directly contact the Participating Specialist to obtain fees, as the amount varies by provider.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. The Invisalign system and similar appliances are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.

Plan Limitations

1. Two (2) evaluations are covered per calendar year per patient including a maximum of one (1) comprehensive evaluation.
2. One (1) problem focused exam is covered per calendar year per patient.
3. Two (2) teeth cleanings (prophylaxis) are covered per calendar year per patient (one additional cleaning is covered during pregnancy and for diabetic patients).
4. One (1) topical fluoride or fluoride varnish is covered per calendar year per patient.
5. Two (2) bitewing x-rays are covered per calendar year per patient.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years per patient.
7. Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
8. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
9. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
10. Relining and rebasing of dentures is covered once every 24 months per patient.
11. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
12. Root planing or scaling is covered once every 24 months per quadrant per patient.
13. Full mouth debridement is covered once per lifetime per patient.
14. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per twelve (12) months per patient. Must have pocket depths of five (5) millimeters or greater.
15. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site per patient.
16. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy, per patient.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

Access PPO Basic

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%
Endo/Perio	Class III Benefits			Class III Benefits		

Annual Deductible	**In-Network**	**Out-of-Network**
Amount	$50	$50
Max for Adults	$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.

Waiting Periods	**In-Network**	**Out-of-Network**
Class I	NONE	NONE
Class II	NONE	NONE
Class III	NONE	NONE
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar Year per Member – maximum $150 for adults.
- 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.

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 Include:

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

Class II. Basic Services, Include:

1. Simple extraction of teeth
2. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Periapical x-rays
4. One full mouth or panoramic x-ray per 60 months
5. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
6. Antibiotic injections administered by a dentist

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
   b. One scaling and root planing per quadrant (D4341 or D4342) of mouth 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
   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 placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges (including acid etch metal 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, employer's liability laws, or the Pennsylvania Motor Vehicle Financial 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) 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.

Access PPO Plus

Benefit Coverage	In-Network	Out-of-Network
Class I	100%	90%
Class II	50%	40%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	*Class III & II/III Benefits*	*Class III & II/III Benefits*

Annual Deductible	In-Network	Out-of-Network
Amount	$50	$50
Max for adults	$150	$150
Applies to all Benefits	Yes	Yes

Maximums	In-Network	Out-of-Network
Annual	$750	$750
Lifetime Ortho	N/A	N/A

* Annual Maximum applies to Class I, Class II and Class III Benefits.

Waiting Periods	In-Network	Out-of-Network
Class I	NONE	NONE
Class II	NONE	NONE
Class III	NONE	NONE
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar Year per Member – maximum $150 for adults.
- 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.

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

Class I. Diagnostic and Preventive Services:

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

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. Periodontic services, limited to:
   a. Two periodontal maintenance visits following surgery per Calendar Year
   b. One scaling and root planing per quadrant (D4341 or D4342) of mouth per 24 months from age 21
   c. Occlusal adjustment performed with covered surgery
   d. One appliance (night guards) per 5 years within 6 months of osseous surgery
   e. One full mouth debridement per lifetime

Class III. Major Services: Not Covered

1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Periodontic services, limited to:
   a. Gingivectomy
   b. Osseous surgery including flap entry and closure
   c. One pedicle or free soft tissue graft per site per lifetme
3. 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
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 placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges (including acid etch metal 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, employer's liability laws, or the Pennsylvania Motor Vehicle Financial 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) 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.

Access PPO Premium

Benefit Coverage	In-Network	Out-of-Network
Class I	100%	90%
Class II	80%	70%
Class III	50%	40%
Class IV	0%	0%
Endo/Perio	*Class III Benefits*	*Class III Benefits*

Annual Deductible	In-Network	Out-of-Network
Amount	$50	$50
Max for Adults	$150	$150
Applies to all Benefits	*No, Waived on Class I Benefits*	*No, Waived on Class I Benefits*

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

* Annual Maximum applies to Class I, Class II and Class III Benefits.

Waiting Periods	In-Network	Out-of-Network
Class I	NONE	NONE
Class II	6 Months	6 Months
Class III	12 Months	12 Months
Class IV	N/A	N/A

- Deductible is combined for all services for each Calendar Year per Member – maximum $150 for adults.
- 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.

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

Class I. Diagnostic and Preventive Services:

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

Class II. Basic Services:

1. Simple extraction of teeth
2. Amalgam and composite fillings (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

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 placed or last replaced
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
10. Prosthetic services, limited to:
    a. Initial placement of removable dentures or fixed bridges
    b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months

Class IV. Orthodontia Services: Not Covered

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

Plan Exclusions:

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

Dental Subscribers Can Also Enroll in our Vision Plan!

Vision Plan 6030 At a Glance

Rates		Vision 6030	
Monthly Premium	Member	$8.42	
	Member + 1	$14.58	
	Member + 2 or More	$21.10	
Benefit Summary		**Copayments**	**Frequency**
	Exam	$10	12 Months
	Lenses	$10	12 Months
	Frames	None	12 Months
	Contact Lenses (instead of glasses)	None	12 Months
Lenses Benefit Options (in-network) (in addition to lenses copayment above)			
	UV Coating	$12	
	Tint	$10	
	Scratch Resistance	$10	
	Polycarbonate	$25	
	Anti-Reflective	$40	
	Standard Progressive	$50	
	Other Add Ons	Retail Discount	
Maximum Allowances[1]		**Preferred Provider**	
	Frame	$120	
	Contact Lenses (instead of glasses)	$100	
		Non-Preferred Provider	
	Exam	$32	
	Frames	$60	
	Single Vision Lenses	$24	
	Bifocal Lenses	$36	
	Trifocal Lenses	$46	
	Contact Lenses	$75	

[1] The scheduled amounts shown are the maximum allowable amount. The actual amount to be paid for any service or material will be the lesser of the scheduled amount for such service rendered and/or materials purchased, or the actual amount charged. There is no assurance that the scheduled amount will be sufficient to pay the full cost of the service rendered or the materials selected.

Vision Plan 6030

You may use any licensed vision provider or choose from over 50,000 participating providers nationwide including Wal-Mart, Pearle Vision, Sears Optical, J.C. Penney, For Eyes Optical, Hour Eyes and Target Optical, along with independent optometrists, ophthalmologists and opticians.[2]

In-Network Benefits Include:

- **Eye Examination:** Covered 100% after a $10 copay.
- **Eyeglass Lenses:** Covered 100% after a $10 copay per pair. Lens options purchased from a participating provider will be provided to the member at a fixed price (does not apply to Wal-Mart locations). Please refer to your coverage schedule for specific pricing.
- **Frames:** Any frame up to a retail price of $120. The member is responsible for frame costs exceeding $120, less a 30% discount (for example, if the frame costs $220, the plan covers $120 and the member is responsible for the remaining balance of $100. Instead of paying the full $100, the member gets a 30% discount and pays only $70).
- **Contact Lenses[3]:** Any pair of contact lenses up to a retail price of $100 (member cannot have eyeglass lenses and contact lenses covered under the plan in the same 12-month period). The member is responsible for contact lens costs exceeding $100, less a 25% discount (for example, if the contact lenses cost $200, the plan covers $100 and the member is responsible for the remaining balance of $100. Instead of paying the full $100, the member gets a 25% discount and pays only $75).

A mail order discount program is also available by ordering online through Contact Fill at contactfill.com or toll-free at 866-234-1393.

- **LASIK** - Non-Insured Discount Benefit: Members will receive a 15% discount off of standard prices or a 5% discount off of promotional prices.

Out-of-Network Benefits Include:

While Dominion offers access to a leading national network through National Vision Administrators (NVA), members may choose to go outside the network using any licensed vision provider. Please refer to the description of benefits on the next page, which will outline coverage if a non-participating provider is utilized.

[2] All other brand names, product names or trademarks belongs to their respective holders.
[3] Instead of glasses

* Please note the benefits are licensed vision products, but they are not pediatric vision essential health benefits offered by a stand-alone vision plan under the Affordable Care Act.

Vision Plan 6030

	Copayments	Frequency
Exam	$10	12 months
Lenses	$10	12 months
Frames	None	12 months
Contact Lenses	None	12 months

Lenses Benefit Options (in-network)
(in addition to lenses copayment above)

UV Coating	$12
Tint	$10
Scratch Resistance	$10
Polycarbonate	$25
Anti-Reflective	$40
Anti-Reflective	$40
Other Add Ons	Retail Discount

Maximum Allowances[1]
Preferred Provider:

Frame	$120
Contact Lenses	$100

(instead of glasses)
Non-Preferred Provider:

Exam	$32
Frames	$60
Single Vision Lenses	$24
Bifocal Lenses	$36
Trifocal Lenses	$46
Contact Lenses	$75

[1] The scheduled amounts shown are the maximum allowable amount. The actual amount to be paid for any service or material will be the lesser of the scheduled amount for such service rendered and/or materials purchased, or the actual amount charged. There is no assurance that the scheduled amount will be sufficient to pay the full cost of the service rendered or the materials selected.

Plan will pay for eligible expenses (subject to benefit coverage) incurred by or on behalf of Subscriber and/or their Dependents while covered under the Policy including:

A. Services: Include, but are not limited to:

1. Vision Examinations - Each Subscriber and eligible Dependent(s) is entitled to a complete analysis of the eyes and related structures to determine vision problems and other abnormalities. Plan will cover such service once every 12 months. Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such materials will be covered, together with certain services as necessary.
2. Prescribing and ordering proper lenses.
3. Assisting with selection of frames.
4. Verifying accuracy of finished lenses.
5. Proper fitting and adjustments.

B. Materials:

1. Lenses: Plan will pay for lenses on a new prescription for standard lenses once every 12 months. The lens allowance equals two (2) lenses. If only one (1) lens is needed the allowance will be half (1/2) the lens allowance.
2. Frames: Plan will pay for frames once every 12 months.
3. Contact Lenses: Plan will pay for contact lenses once every 12 months.

C. Benefits:

Participating Provider shall mean a licensed provider who has contracted to accept, as full payment, Member's copayment and the contracted payment from Plan. Plan will pay benefits if the services are rendered or materials are furnished by a Participating Provider.

Use of a Participating Provider does not guarantee that all expenses will be covered under the Policy. Participating Provider locations are identified by contacting the Plan's Member Services Department or the website.

Services and materials will be covered at the benefit levels for a Non-Participating Provider when: a) the provider rendering the service or furnishing the materials is no longer a Participating Provider; or b) the Member elects not to use the services or materials of the Participating Provider.

Non-Participating Provider shall mean a licensed provider NOT under contract with Plan. After the applicable copayment, Plan will pay the reasonable and customary charge for services and materials, up to the scheduled amount shown in this document.

Benefits will be payable the same as for a Participating Provider when: a) a Participating Provider refers the Member to a Non- Participating Provider because the Participating Provider is unable to render the necessary service or furnish the necessary materials; or b) a Non- Participating Provider is on call in the absence of the Participating Provider.

Plan may not prohibit the assignment of benefits to a Provider by a Member or refuse to directly insure a Non-Participating Provider under an assignment of benefits.

Plan Limitations: In no event will payment exceed the lesser of:

1. The actual cost of covered services or materials; or
2. The limits of the Policy, shown in this schedule.

Plan Exclusions:

1. 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.
2. Services which are covered under Medicare, worker's compensation, employer's liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law (Pennsylvania policyholders only).
3. Services and treatment provided without charge or for which there would be no charge in the absence of insurance. DOES NOT APPLY TO MEDICAID.
4. Services not listed as covered.
5. Hospitalization for any vision procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Orthoptic or vision training and any associated supplemental testing.
8. Plano lenses.
9. Two pair of glasses, in lieu of bifocals or trifocals.
10. Medical or surgical treatment of the eyes.
11. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
12. Customization of bifocal lenses to a progressive or no-line lens.
13. Photo-chromatic lenses.
14. Sub-normal vision aids or non-prescription lenses.
15. Services rendered or materials purchased outside the U.S. or Canada, unless: a) the Member resides in the U.S. or Canada; and b) the charges are incurred while on a business or pleasure trip.
16. Charges in excess of the usual and customary charge for the service or materials.
17. Charges incurred after: a) the Policy ends; or b) the Member's coverage under the Policy ends, except as stated in the Policy. Maryland policyholders only: Also subject to the Extension of Benefits provision.
18. Experimental or non-conventional treatment or device as determined by treating provider.
19. Spectacle lens treatments or "add-ons," except solid tints (#1 & #2), and oversize lenses.
20. High Index lenses of any material type.
21. Lost or broken materials, except when replaced at normal intervals when services are available.
22. Maryland policyholders only: Any bill, or demand for payment, for a vision 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.

Who is Eligible for the Dental & Vision Plan?

You and your dependents are eligible. Dependents include your spouse and unmarried children up to age 26.

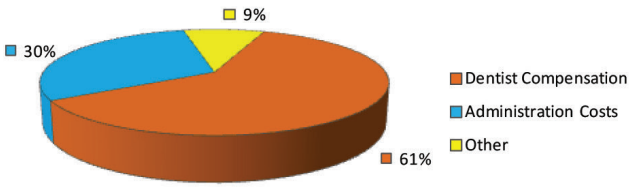
How do I Join the Dental & Vision Plan?

1. To pay annually by check, complete the Enrollment Card and submit it with a check for 12 months of premium. Go to Step 3.
2. To pay by debit to your checking account or credit card account, please fill out the Payment Authorization Card.
   - When you choose the monthly payment option future monthly installments will be debited directly from your account. You will not receive monthly bills. Please attach a voided check to Payment Authorization Card when selecting this option.
   - There is a minimum participation requirement of one year.
3. Fill out the Enrollment Card. Be sure to list all dependents you want covered. Additional dependents can be listed on the back of the Enrollment Card, if necessary.
   - Select either the Discount Program, Select Plan or Access PPO Plan. You do not have to enroll in a dental benefit to enroll in the vision plan.
   - If you choose either the Discount Program or the Select Plan, please select a dentist and fill in the Dental Office Name & Code # box.
   - Sign and date the appropriate section of the Enrollment Card.
4. Return the completed Enrollment Card, Payment Authorization Card (if applicable) or payment (if applicable) to:
   Dominion Dental Services, Inc.
   P.O. Box 75314
   Charlotte, NC 28275-5314

   - A Membership Card and coverage information will be mailed to you on or before your first day of eligibility.

The following explanation as required by the Maryland Insurance Administration.

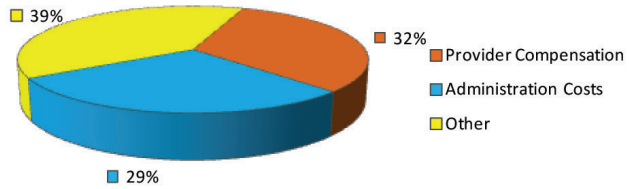
Access PPO & Select Plan Premium Dollar Distribution



Dominion is licensed as a Dental Plan Organization (DPO) in the State of Maryland. Access PPO dentists are paid through the traditional discounted fee-for-service model. Select Plan network dentists are paid through a combination of member copayments and capitation dollars (predetermined monthly payments per member).

This chart shows how premium dollars were distributed in 2014 between dentist compensation and administration costs.

Vision Premium Dollar Distribution



This chart shows how premium dollars were distributed in 2014 between provider compensation and administration costs.

DOMINION® DENTAL Services, Inc.
115 South Union Street, Suite 300
Alexandria, VA 22314
888-518-5338 (Phone)
855-485-0115 (Fax)
DominionDental.com

DominionDental.com/eDental/nacba

Payment Authorization Card

Our Pre-authorized Payment Plan

Just authorize us to debit your personal checking account ***or*** credit card account and we'll do the rest. There will be no more paperwork, no more checks to write and no worries about coverage disruption. It's easy, secure, and automatic.

Pay By Credit Card Debit: ❑ **Automatic Monthly Debits**

Credit Card Number: _____ C.C. Verification Code: _____

Credit Card Type: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Name as it appears on card: _____

Expiration Date: _____

Pay By Checking Account Debit: ❑ **Automatic Monthly Debits**

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

* By submitting a check for the first month's premium and application fee, you authorize Dominion Dental Services, Inc. to automatically deduct future monthly premium payments from your checking account.

Terms and Authorization

Payment Authorization: By signing the *Payment Authorization* form you authorize Dominion Dental Services Inc. to automatically deduct premium payments from the credit card or checking account noted above. By selecting the Automatic Monthly Debits option you further agree to automatic deductions of future monthly premiums.

Application Fee: ~~There is a one-time, non-refundable $20 application and processing fee. When paying by Automatic Monthly Debit to your checking account or credit card account, you will be charged the application fee along with your first month's premium. When paying by Annual Payment you will be charged for 12 months of premium plus the $20 application fee.~~ **THERE IS NO APPLICATION FEE!**

Pay By Credit Card: By selecting the Automatic Monthly Debits option you authorize Dominion Dental Services Inc. to automatically deduct future monthly premium payments from your credit card account.

Pay By Bank Account Debit: By selecting the Automatic Monthly Debits and submitting a voided check you authorize Dominion Dental Services Inc. to automatically deduct future monthly premium payments from your checking account.

TERMS: This authorization will remain in effect unless 30 days advance written notice of termination is received by Dominion Dental Services, Inc. In the event that any electronic debit or transfer is returned, I agree that a $25.00 returned item fee will be automatically charged to my account.

AUTHORIZATION: I authorize Dominion Dental Services, Inc. to automatically deduct the premium and application fee from any credit card OR bank account stated above. Members who choose the Automatic Monthly Debits will be debited on or about the 20th of each month (subscribers enrolling in Maryland will be debited on or after the 1st of each month).

Signature: _____ **Date:** _____

Agent/Broker Use Only

Agent/Broker # _____ General Agent # _____

Non-Virginia Residents

Dominion Dental Services, Inc.
Alexandria, VA

Avalon Insurance Company
Harrisburg, PA

Dental/Vision Enrollment Card

DENTAL
SELECT ONE:
- ☐ I choose the Dominion Discount Program[1]
- ☐ I choose the Dominion Select Plan[2]
- ☐ I choose the Dominion Access PPO[2]
  - ☐ Access PPO Basic
  - ☐ Access PPO Plus
  - ☐ Access PPO Premium

VISION
SELECT ONE:
- ☐ I choose the Avalon vision[3] plan 6030

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	

Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Hire Date

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse				
Child				
Child				
Child				
Child				
Child				
Child				

SELECT PLAN or DISCOUNT PROGRAM Provider Selection	Dental Office Name & Code # (As Indicated on Your Dentist Directory)

If I am enrolling in the Select Plan and I am voluntarily paying 100% of the cost of this plan, without employer contribution, I agree to remain in plan a minimum of twelve (12) months. If I cancel before the end of the 12 month period, I may be responsible for the usual, customary and reasonable charges for services received, reduced by the sum of the subscription dues and copayments paid.

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion Dental Services, Inc., if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Group #	Group Name	Coverage Eff. Date
112100000001	3720000		

Dominion Dental Services USA, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

[1] This is a reduced fee-for-service program designed specifically for individuals. It is not an insurance product, regulated by the State Insurance Department, or covered by any state's guarantee fund or corporation.
[2] The dental plans are underwritten by Dominion Dental Services, Inc.
[3] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Vision Services.

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. District of Columbia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dominion Dental Services, Inc. — Alexandria, VA

Discount Program Enrollment Card

☐ I choose the Dominion Discount Program[1]

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address	Home Phone	
City / State / ZIP	Work Phone	
Email Address		
Does this plan replace other coverage? ☐ Yes ☐ No		
Please check the appropriate dependent coverage ☐ Subscriber Only ☐ Subscriber & 1 or More Dependents		

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse				
Child				
Child				
Child				
Child				
Child				
Child				

DISCOUNT PROGRAM Provider Selection — Dental Office Name & Code # (As Indicated on Your Dentist Directory)

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Program and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by dentists and other providers of dental services. Information will be released to Dominion Dental Services USA for the purpose of Quality Assurance and/or utilization review. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date	**7000x**
1121000000013720000		

Dominion Dental Services USA, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

[1] This is a reduced fee-for-service program designed specifically for individuals. It is not an insurance product, regulated by the State Insurance Department, or covered by any state's guarantee fund or corporation.

Dominion Dental Services, Inc.
Alexandria, VA

Avalon Insurance Company
Harrisburg, PA

Dental/Vision Enrollment Card

DENTAL ☐ I choose the Dominion Select Plan[1]
SELECT ONE: ☐ I choose the Dominion Access PPO[1]
☐ Access PPO Basic
☐ Access PPO Plus
☐ Access PPO Premium

VISION ☐ I choose the Avalonvision[2] plan 6030
SELECT ONE:

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address		Home Phone
City	State / ZIP	Work Phone
Email Address		Hire Date

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse				
Child				
Child				
Child				
Child				
Child				
Child				

SELECT PLAN
Provider Selection

Dental Office Name & Code #
(As Indicated on Your Dentist Directory)

If I am enrolling in the Select Plan and I am voluntarily paying 100% of the cost of this plan, without employer contribution, I agree to remain in plan a minimum of twelve (12) months. If I cancel before the end of the 12 month period, I may be responsible for the usual, customary and reasonable charges for services received, reduced by the sum of the subscription dues and copayments paid.

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion Dental Services, Inc., if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Group #	Group Name	Coverage Eff. Date
1121000000013	720000		

Dominion Dental Services USA, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

[1] The dental plans are underwritten by Dominion Dental Services, Inc.
[2] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Vision Services.

Virginia - Any person who, with the intent to defraud or knowing that s/he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.