

## Choice PPO 1

| <b>Benefit Coverage</b>                                      | <b>In-Network</b>            | <b>Out-of Network</b>        |
|--|------------------------------|------------------------------|
| Class I  | 100%                         | 100%                         |
| Class II   | 80%                          | 80%                          |
| Class III  | 50%                          | 50%                          |
| Class IV   | 0%                           | 0%                           |
| Endo/Perio/Oral Surgery                                      | Class III Benefits           | Class III Benefits           |
| <b>Annual Deductible</b>                                     |                              |                              |
|  | <b>In-Network</b>            | <b>Out-of-Network</b>        |
| Amount   | \$50                         | \$50                         |
| Max Per Family   | \$150                        | \$150                        |
| Applies to all Benefits                                      | <i>No, Waived on Class I</i> | <i>No, Waived on Class I</i> |
| <b>Maximums</b>  |                              |                              |
|  | <b>In-Network</b>            | <b>Out-of-Network</b>        |
| Annual   | \$1,000                      | \$1,000                      |
| Lifetime Ortho   | N/A                          | N/A                          |
| * Annual Maximum applies to Class II and Class III Benefits. |                              |                              |
|  | <b>In-Network</b>            | <b>Out-of-Network</b>        |
| <b>Out-of-Network Allowance</b>                              | N/A                          | PPO Fee                      |
| <b>Waiting Periods</b>                                       |                              |                              |
|  | <b>In-Network</b>            | <b>Out-of-Network</b>        |
| 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 per family.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed \$300, prior review is requested
- Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

**Dominion National Insurance Company**  
**251 18th Street South; Suite 900**  
**Arlington, VA 22202**  
**800.811.4793**  
**DominionNational.com**

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

**Class I. Diagnostic and Preventive Services:**

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

**Class II. Basic Services:**

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

**Class III. Major Services:**

1. Oral surgery, including postoperative care for:
  - a. Removal of teeth, including impacted teeth
  - b. Extraction of tooth root
  - c. Alveolectomy, alveoplasty, and frenectomy
  - d. Excision of periocoronal gingiva, exostosis, or hyperplastic 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
  - g. Coronectomy, intentional partial tooth removal, one (1) per lifetime
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
  - i. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years
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. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one per 60 months from the original date of placement, per permanent tooth, per patient
  - b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced
  - c. Stainless steel crowns up to age 14 (one per tooth per lifetime)
  - d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally

10. Prosthetic services, limited to:

- a. Initial placement of removable dentures or fixed bridges
- b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement
- c. Addition of teeth to existing partial denture
- d. One relining or rebasing of existing removable dentures per 24 months

**Class IV. Orthodontia Services: Not Covered**

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

**Plan Exclusions:**

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