

**Access PPO Plan  
100/80/0/0**

<b>Benefit Coverage</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Class I	100%	100%
Class II	80%	80%
Class III	0%	0%
Class IV	0%	0%
Endo/Perio	<i>Class II Benefits</i>	<i>Class II Benefits</i>

<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 Benefits</i>	<i>No, Waived on Class I Benefits</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 I, Class II and Class III Benefits.

<b>Waiting Periods</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Class I	NONE	NONE
Class II	NONE	NONE
Class III	N/A	N/A
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.

*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. 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 excluding posterior composite fillings (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 diagnostic x-ray, full or panoramic 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
7. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)
8. 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
9. Periodontic services, limited to:
  - a. Two periodontal cleanings following surgery per Calendar Year (D4341 is not considered surgery)
  - b. One root scaling and planing per quadrant of mouth per 24 months from age 21
  - c. Occlusal adjustment performed with covered surgery
  - d. Gingivectomy and gingival curettage
  - 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

**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 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
2. One study model per 36 months
3. Crown build-up for non-vital teeth
4. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter
5. One repair of dentures or fixed bridgework per 24 months
6. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery
7. Restoration services, limited to:
  - a. Gold or porcelain inlays, onlays, and crowns 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 (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage)
  - 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
8. Prosthetic services, limited to:
  - a. Initial placement of dentures or fixed bridgework (including acid etch metal bridges)
  - b. Replacement of dentures or fixed bridgework 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 (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth)

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

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

**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.
3. Services and treatment provided without charge or for which there would be no charge in the absence of insurance.
4. Services not listed as covered.
5. Hospitalization for any dental procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
8. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
11. Services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
12. Oral hygiene instructions; plaque control; completion of a claim form; acid etch; broken appointments; prescription or take-home fluoride; or diagnostic photographs.
13. Dispensing of drugs.
14. Diagnosis or treatment of temporomandibular joint (TMJ) syndromes, problems and/or occlusal disharmony.
15. Procedures that in the opinion of Dominion Dental Services 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, anodontia, 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 Plan Coverage Schedule

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