



# Access PPO Adults

## Maximum access, convenience and flexibility.

### Benefit Features

Deductibles:	\$50 (\$150) per family
Annual Maximum:	\$1,000
Waiting Periods:	None
Receive Care From:	Any Dentist or Access PPO Dentist

### Adult (Age 19 and Over)

- Use any dentist or one of over 217,000 network dentist listings nationwide.<sup>1</sup>
- The use of a network dentist can significantly reduce your out-of-pocket costs (Dominion members save an average of 11%).<sup>2</sup> Out-of-network dentists may charge above the amount covered by the Dominion plan, which will be balanced billed to you, the member. To ensure you do not receive additional out-of-pocket charges, visit a dentist in the Dominion Dental PPO network.
- No waiting periods.
- No charge for in-network exams, cleanings, bitewing X-rays and other preventive services.
- \$1,000 annual maximum per adult member.
- Basic and Major Care services are covered at increasing levels in the second and third year.

### About Dominion

Dominion Dental Services (Dominion), incorporated in 1996, is a leading provider and administrator of dental and vision benefits in the Mid-Atlantic, offering managed care and indemnity programs, claims adjudication and comprehensive plan administration. Among our 550,000 customers are leading health plans, employer groups, municipalities, associations and individuals.

The Dominion Group of companies includes Dominion Dental Services, Inc., a licensed issuer of dental plans, and Dominion Dental Services USA, Inc., a licensed administrator of dental and vision benefits.

<sup>1</sup> Participating dentists are subject to change.  
<sup>2</sup> Dominion Dental Services, Inc. - based on review of 2nd Quarter 2014 PPO claims data.



**We Work For Your Benefit.®**

**For full details of the coverages, limitations and exclusions, please read the Summary of Benefits.**

**Need to find a participating dentist?  
Simply visit [DominionDental.com/health-care-reform](http://DominionDental.com/health-care-reform)  
or call 888-518-5338.**

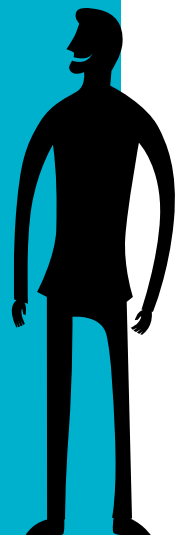
Dominion is a Qualified Health Plan issuer in the DC Health Link, Delaware Health Insurance Marketplace, Maryland Health Connection, Pennsylvania Health Insurance Marketplace and Virginia Health Insurance Marketplace.

### A New Level of Service<sup>1</sup>

- Less than 0.1% of our members called with a service issue.
- 96% member satisfaction rate.<sup>2</sup>
- 98% of Dominion members have access to at least two PPO dentists within 10 miles.
- Our PPO network increased by 20% in the last year.

<sup>1</sup> Dominion Dental Services, Inc. Internal Performance Report, 2013.

<sup>2</sup> Dominion Dental Services, Inc. Member Satisfaction Survey, January 2014.



## Access PPO SHOP *Adults*

### Coverage Schedule for Adult Services

- age 19 and over -

#### Access PPO SHOP *Adults*

##### Benefit Coverage

Year	<u>In-Network</u>			<u>Out-of-Network</u>		
	1st	2nd	3rd	1st	2nd	3rd
<b>Class I</b>	100%	100%	100%	90%	90%	90%
<b>Class II</b>	40%	60%	80%	30%	50%	70%
<b>Class III</b>	15%	25%	50%	10%	20%	40%
<b>Endo/Perio</b>	Class III Benefits			Class III Benefits		

##### Annual Deductible    In-Network    Out-of-Network

Single Adult	\$50	\$50
Three or More Adults	\$150	\$150
Applies to all Benefits	Yes	Yes

##### Maximums                      In-Network    Out-of-Network

Annual	\$1,000	\$1,000
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\* 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 Plan Year per adult Member – maximum \$150 for adult Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed \$300, prior review is requested.

**Dominion Dental Services, Inc.**  
**115 South Union Street**  
**Suite 300**  
**Alexandria, VA 22314**  
**(888) 518-5338**  
**DominionDental.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 Include:**

1. Two evaluations per Plan Year including a maximum of one comprehensive evaluation
2. One emergency or problem focused exam (D0140) per Plan Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Plan Year
4. Bitewing x-rays, 2 per Plan 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 (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations)
3. Periapical x-rays
4. One diagnostic x-ray, full or panoramic per 36 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 pericoronal 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
3. Periodontic services, limited to:
  - a. Two periodontal cleanings following surgery per Plan Year (D4341 is not considered surgery)
  - b. One root scaling and planing per quadrant of mouth per 6 months
  - c. Occlusal adjustment performed with covered surgery
  - d. Gingivectomy and gingival curettage
  - e. Osseous surgery including flap entry and closure
  - f. Pedicle or free soft tissue graft
  - 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
7. One repair of dentures or fixed bridgework per 24 months
8. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery
9. 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 5 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
  - 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 dentures or fixed bridgework (including acid etch metal bridges)
  - b. Replacement of dentures or fixed bridgework that cannot be repaired after 5 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 12 months from date of last placement)

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

Diagnostic, active and retention treatment to include removable fixed appliance therapy 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. 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.
13. Services not listed as covered.
14. Implants; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
15. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
16. 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.
17. Treatment of cleft palate, malignancies or neoplasms.
18. 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.



# Access PPO Kids

## Maximum access, convenience and flexibility.

### Benefit Features

Deductibles:	\$100 (\$200)
Out-of-Pocket Maximum:	\$350
Waiting Periods:	None <sup>1</sup>
Receive Care From:	Any Dentist or Access PPO Dentist

### Pediatric (Under Age 19)

- Members can use any dentist or one of over 217,000 network dentist listings nationwide.<sup>2</sup>
- Significant out-of-pocket savings if using an in-network dentist.
- No waiting periods for non-orthodontic services.
- No charge for in-network exams, cleanings, bitewing X-rays and other preventive services.
- Medically necessary orthodontic benefits.
- Out-of-pocket member's maximum is \$350 per child per calendar year for medically necessary treatment, with a maximum of \$700 for two or more children.

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The Dominion Group of companies includes Dominion Dental Services, Inc., a licensed issuer of dental plans, and Dominion Dental Services USA, Inc., a licensed administrator of dental and vision benefits.

<sup>1</sup> There is a 24-month waiting period for medically necessary orthodontic benefits.  
<sup>2</sup> Participating dentists are subject to change.



### We Work For Your Benefit.®

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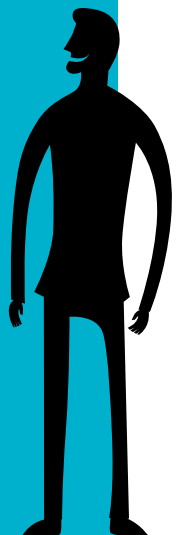
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- Our PPO network increased by 20% in the last year.

<sup>1</sup> Dominion Dental Services, Inc. Internal Performance Report, 2013.

<sup>2</sup> Dominion Dental Services, Inc. Member Satisfaction Survey, January 2014.



## Access PPO Kids (MD)

### Coverage Schedule for Pediatric Services - under age 19 -

<u>Benefit Coverage</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Class I	100%	80%
Class II	35%	20%
Class III	25%	10%
Class IV	50%	30%
Endo/Perio	<i>Class III Benefits</i>	<i>Class III Benefits</i>

<u>Annual Deductible</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Single Child	\$100	\$100
Two or More Children	\$200	\$200
Applies to all Benefits	<i>No, Waived on Class I &amp; IV Benefits</i>	<i>No, Waived on Class I Benefits</i>

<u>Out-of-Pocket Maximums</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Single Child	\$350	N/A
Two or More Children	\$700	N/A

\* Annual Out-of-Pocket Maximum applies to all covered services for medically necessary treatment.

**Waiting Periods:** There are no waiting periods with the exception of medically necessary orthodontia, which requires a 24-month waiting period.

- Deductible is combined for all covered services for each calendar year per pediatric Member – maximum \$200 for pediatric Members.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed \$300, pre-authorization is required.

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

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

1. Two evaluations (D0120, D0145, D0150 or D0160) per calendar year per patient
2. One re-evaluation limited, problem focused or periodontal exam (D0170 or D0180) per calendar year; limited oral evaluation (D0140)
3. Two prophylaxis (D1110 or D1120) per calendar year per patient
4. Four fluoride treatments are covered per calendar year, per patient, (ages 0-2 eight fluoride varnishes per calendar year, per patient) including topical application of fluoride
5. Bitewing x-rays, two per calendar year, starting at age two
6. Periapical x-rays
7. One full mouth x-ray or panoramic film (starting at age six) per 36 months; maximum of one set of x-rays per provider/location
8. One space maintainer (D1515 or D1525) per 24 months, per patient, per arch to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)
9. One sealant per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)
10. Other diagnostic imaging (D0290, D0310, D0320, D0321)

#### Class II. Basic Services:

1. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 36 months
2. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
3. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
4. General anesthesia and analgesic, including intravenous and non-intravenous sedation with a maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure codes D9230, D9241 or D9242; intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230; analgesia (nitrous oxide) is not covered with procedure codes D9220, D9221, D9241 or D9242); requires a narrative of medical necessity be maintained in patient records
5. Hospital call (facility and anesthesia charges are covered and covered under medical insurance; services delivered to the patient on the date of service are documented separately using applicable procedure codes); requires coordination and approval from both the dental insurer and the medical insurer before services can be rendered
6. Occlusal guard with covered surgery, by report, per 24 months

#### Class III. Major Services:

1. Oral surgery, including postoperative care for:
  - a. Removal of teeth, including impacted teeth
  - b. Extraction of tooth root or partial tooth
  - c. Alveolectomy, alveoplasty, frenectomy and vestibuloplasty
  - d. Excision of pericoronal gingiva, exostosis or hyperplastic tissue, and excision of oral tissue for biopsy
  - e. Reimplantation or transplantation of a natural tooth
  - f. Excision of a benign lesion, tumor or cyst and incision and drainage of an abscess or cyst
  - g. Biopsy of oral tissue (D7285, D7286)
2. Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to:
  - a. Root canal therapy; once per lifetime, per patient, per permanent tooth; Retreatment of previous root canal therapy, one per tooth, per lifetime, not within 24 months when done by same dentist or dental office
  - b. Pulpotomy
  - c. Pulpal therapy
  - d. Apexification/recalcification
  - e. Apicoectomy
  - f. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
  - a. Two periodontal cleanings following surgery (D4341 is not considered surgery) per plan year after definitive periodontal therapy
  - b. One root scaling and planing, once per 24 months, per patient, per quadrant
  - c. Occlusal adjustment performed with covered surgery
  - d. Gingivectomy and gingival curettage, once per 24 months, per patient, per quadrant
  - e. Anatomical crown exposure and clinical lengthening
  - f. Osseous surgery including flap entry and closure, once per 24 months, per patient, per quadrant
  - g. Provisional splinting
  - h. One pedicle or free soft tissue graft per site, per lifetime
  - i. One full mouth debridement per 24 months
  - j. Localized delivery of chemotherapeutic agents is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per 12 months (must have pocket depths of five millimeters or greater)

- k. Periodontal maintenance limited to twice per 12 months after definitive periodontal therapy
4. One study model per 36 months
5. Restoration services, limited to:
  - a. Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite inlay, onlay, or crown for teeth 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 (D2930, D2932, D2933, D2934 one per 36 months from the original date of placement, per primary tooth, per patient)
  - b. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
  - c. Sedative filling
  - d. Post removal
  - e. Crown build-up for non-vital teeth
  - f. Labial veneer per 60 months, per arch
6. Prosthetic services, limited to:
  - a. Initial placement of dentures
  - b. Repair of dentures twice per year and five total per five years
  - c. Replacement of dentures that cannot be repaired after five years from the date of last placement
  - d. Addition of teeth or clasp to existing partial denture
  - e. Relining or rebasing of existing removable dentures; rebonding or recementing fixed denture
  - f. Adjustment and maintenance of maxillofacial prosthetics, limited to D5992 and D5993, one each per patient, per six months, per arch
  - g. Overdenture per 60 months, per arch

#### Class IV. \*MEDICALLY NECESSARY\* Orthodontia Services:

Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion. A 24-month waiting period applies to medically necessary orthodontia.

#### 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. 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, 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 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 with the exception of a retainer.
10. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth. The prophylactic removal of these teeth may be covered subject to review.
11. 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.
12. Services not listed as covered.
13. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function. Bridges are not covered.
14. 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.
15. Treatment of cleft palate (if not treatable through orthodontics), malignancies or neoplasms.
16. Orthodontics is only covered if medically necessary as determined by the Plan. There is a 24-month waiting period for Medically Necessary Orthodontia. The Invisalign system and similar specialized braces are not a covered benefit. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.