Dominion National

www.FederalDentalPlans.com

(855) 836-6337

DOMINION NATIONAL

2027

A Regional Copay Based Dental EPO Plan

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 4
- Summary of Benefits: Page 41

Serving:

Mid-Atlantic States of District of Columbia, Delaware, Maryland, Pennsylvania, parts of Virginia and parts of New Jersey

This plan has three enrollment regions; please see the end of this brochure to determine your region and corresponding rates.

Options:

High Option - Self Only
High Option - Self Plus One
High Option - Self and Family

Standard Option - Self Only
Standard Option - Self Plus One
Standard Option - Self and Family

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The law directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-328, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits under Dominion Dental Services, Inc.'s contract OPM02-FEDVIP-02AP-06 with OPM, as authorized by the FEDVIP law. "Dominion National" is the brand name for Dominion Dental Services, Inc. The address for Dominion National's administrative office is:

Dominion National
251 18th Street South, Suite 900
Arlington, VA 22202
855-836-6337
https ://www. FederalDentalPlans.com

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. You and your family members do not have a right to benefits that were available before January 1, 2027 unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits, if they are also listed on the coverage.

OPM negotiates benefits and rates with each carrier annually. Rates are shown at the end of this brochure.

Dominion National is responsible for the selection of in-network providers in your area. Contact us at 855-836-6337 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website https ://www. FederalDentalPlans.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not for a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you may nominate them to join. Nomination forms are available on our website at https ://www. FederalDentalPlans.com or call us and we will have a form sent to you. You cannot change plans, outside of open season, because of changes to the provider network.

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

The Dominion National plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program / Postal Service Health Benefits (PSHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, https ://www. DominionNational.com, and click on the "Privacy and Compliance Resources" link at the bottom of the page. If you do not have access to the internet or would like further information, please contact us by calling 855-836-6337.

Discrimination is Against the Law

Dominion National complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, Dominion National does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Please visit our website, https ://www. FederalDentalPlans.com, to review our Nondiscrimination and Foreign Language Assistance Notice.

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FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.gov. Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2026 Open Season, your coverage will begin on January 1, 2027. Premium deductions will start with the first full pay period beginning on/after January 1, 2027. You may use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) using post-tax dollars.
Annual Enrollment Opportunity	Each year, an open season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, open season runs from November 9, 2026 through midnight EST December 14, 2026. You do not need to re-enroll each open season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual open season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Waiting Period	There are no waiting periods associated with our plan options.
Compliance with the American Dental Association (ADA)	FEDVIP abides by the Current Dental Terminology (CDT) codification system in accordance with standards set by the American Dental Association (ADA). *Current Dental Terminology (CDT)*, Copyright © American Dental Association. All rights reserved.

How We Have Changed For 2027

We have added the following codes to both the High & Standard Plans for 2027:

- D0417 Collection and preparation of saliva sample for laboratory analysis
- D0426 Collection, preparation, and analysis of saliva sample - point-of-care
- D6049 Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure
- D6280 Implant maintenance procedures when a full arch removable implant/abutment retained denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch
- D9224 Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof
- D9225 Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof
- D9246 Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof
- D9247 Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof
- D9936 Cleaning and inspection of occlusal guard - per appliance

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program, the Postal Service Health Benefits (PSHB) Program, or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program, PSHB Program, or a Health Insurance Marketplace (Exchange) plan is not required.

Temporary/Seasonal Employees

Certain temporary, intermittent, and seasonal Federal and U.S. Postal Service employees are now eligible to enroll in FEDVIP. To be eligible, these employees must be expected to work 130 hours per calendar month for at least 90 days. In addition, certain firefighters hired under a temporary appointment and intermittent emergency response personnel are eligible to enroll in FEDVIP. The employing agency must determine and notify these employees of their eligibility.

Federal Annuitants

You are eligible to enroll if you:

- retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS) or another retirement system for employees of the Federal Government;
- retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government.

Your FEDVIP enrollment will continue into retirement if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB/PSHB Program.

Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.

Survivor Annuitants

If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

TRICARE-eligible individual

An individual who is eligible for FEDVIP dental coverage based on the individual's eligibility to previously be covered under the TRICARE Retiree Dental Program or an individual eligible for FEDVIP vision coverage based on the individual's enrollment in a specified TRICARE health plan. Retired members of the uniformed services and National Guard/Reserve components, including "gray-area" retirees under age 60 and their families are eligible for FEDVIP dental coverage. These individuals, if enrolled in a TRICARE health plan, are also eligible for FEDVIP vision coverage. In addition, uniformed services active duty family members who are enrolled in a TRICARE health plan are eligible for FEDVIP vision coverage.

Family Members

Except with respect to TRICARE-eligible individuals, family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support. FEDVIP rules and FEHB/PSHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in your legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB/PSHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB/PSHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member
- Active duty uniformed service members. **Note:** If you are an active duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).
- Temporary/seasonal employees who do not meet the 130 hours per calendar month for 90 days.

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.gov) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY: 711, International: 1-571-730-5942 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans your enrollment will continue automatically. Please Note: your plans' premiums may change for 2027.

Note: You cannot enroll or change enrollment in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family; however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual (TEI), you may enroll in a dental and/or vision plan during the November 9, 2026 through midnight EST December 14, 2026, Open Season. Coverage is effective January 1, 2027.

During future annual open seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these open season enrollments and changes will be set by OPM. **If you want to continue your current enrollment, do nothing. Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.
- a TRICARE-eligible individual

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDS receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an open season.

The following chart lists the QLEs and the enrollment actions you may take.

From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Moving out of regional plan's service area
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Going on active military duty, non- pay status (enrollee or spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from active military duty (enrollee or spouse)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from Leave without pay
From Not Enrolled to Enrolled: Yes (if enrollment cancelled during LWOP)
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes (if enrollment cancelled during LWOP)

Qualifying Life Event: Annuity/ compensation restored
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Transferring to an eligible position*
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium and you elect to enroll.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan’s service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either plan, you cannot change or cancel that particular enrollment until the next open season, unless you experience a QLE that allows such a change or cancellation.

VA Exception for Cancellation

Generally, you may cancel your enrollment only during the annual open season. However, if you are a FEDVIP enrollee paying premiums on a **post-tax basis**, and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may** change your enrollment type or cancel your enrollment within 60 days of receiving notification of VA dental or vision eligibility. This 60-day period may fall outside of open season. VA dental or vision eligibility documentation must be submitted to OPM via the BENEFEDS mailbox (benefedsportal@opm.gov) within 60 days of notification to support the FEDVIP enrollment change or cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the open season effective date. An eligible family member's coverage also ends upon the effective date of the cancellation.

If you are a FEDVIP enrollee paying premiums on a **pre-tax basis**, and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may not** change or cancel your FEDVIP enrollment until the next open season.

FEDVIP enrollees can verify if they are paying their premiums on a pre- or post- tax basis by contacting BENEFEDS at 1-877-888-3337, TTY: 711, International: 1-571-730-5942.

When Coverage Stops

Coverage ends for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments;
- cancel the enrollment during open season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in a FSAFEDS Health Care Flexible Spending Account (HCFSA), Limited Expense Health Care Flexible Spending Account (LEX HCFSA), or any flexible spending account, you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

Please review IRS - Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (www.irs.gov/forms-pubs/about-publication-969) for additional information about carryover and contribution amounts for the upcoming tax year. If you have an HCFSA or LEX HCFSA FSAFEDS account and you have not exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over a set maximum amount of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st. You must also actively re-enroll in a health care or limited expense account during the next open season to be carryover eligible. Your re-enrollment must meet the minimum contribution amount for the plan year. If you do not re-enroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time permitted. This is known as the “Use-it-or-Lose-it” rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in the program next year.

See www.fsafeds.gov or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. Note: FSAFEDS is not open to retired employees or to TRICARE eligible individuals.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB/PSHB and/or FEDVIP plans.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation	We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You should present your ID card whenever you receive services from an assigned plan provider. If you do not receive your ID card within 30 days after the effective date of your enrollment or if you need replacement cards, you may request one through our website at www.FederalDentalPlans.com or call us at 855-836-6337. You may also obtain a digital ID through Dominion National Go, Dominion's mobile communications service. For more information, please visit www.DominionNational.com/go.
Where You Get Covered Care	You must visit a participating plan dentist to receive treatment. You can find a current list of dentists online at www.FederalDentalPlans.com. You can also call us at 855-836-6337 to request that a list be mailed to you. After your effective date, simply call the participating dental office and make an appointment.
Plan Providers	A complete list of participating dentists are available on our online provider search at www.FederalDentalPlans.com. The list is refreshed every night.
In-Network	You must receive services from a participating dentist or specialist. No referrals are required for specialty care.
Out-of-Network	There are no out-of-network benefits available except for emergency care.
Emergency Services	This is an in-network only plan. Services received outside the network are limited to out-of-area emergency services. You may have emergency services rendered by any licensed dentist when outside the service area. We will reimburse you for emergency services up to $100 per member per year. Emergency services are defined as "palliative care of injury, toothache, or accident requiring the immediate attention of a dentist or hospital/ ambulatory surgical care center." Services are limited to those procedure not excluded under the plan's limitations and general exclusions.
FEHB/PSHB First Payor	When you visit a provider who participates with both, your FEHB/PSHB plan and your FEDVIP plan, the FEHB/PSHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge, in these cases. You are responsible for the difference between the FEHB/PSHB and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB/PSHB first payor. You can assist with this process and also ensure that you are receiving the maximum allowable benefit under each program by presenting both your FEDVIP and FEHB/PSHB ID cards at the time of your dental appointment. The dentist should include both ID numbers when submitting the claim to the plans. It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment because most FEHB/PSHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.
Coordination of Benefits	We will coordinate benefit payments with the payment of benefits under other group health benefits coverage you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault. We may request that you verify/identify your health insurance plan(s) annually or at time of service.
Service Area	To enroll in this plan, you must live in our service area. This is where our providers practice. Our service area is: District of Columbia, Delaware, Maryland, Pennsylvania, parts of Virginia and parts of New Jersey.

Ordinarily, you must get your care from providers within the service area who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits up to $100 per member per year. Emergency services are defined as "palliative care of injury, toothache, or accident requiring the immediate attention of a dentist or hospital/ambulatory surgical care center." Services are limited to those procedures that not excluded under the plan's limitations and general exclusions. We will not pay for any other services out of our service area unless the services have prior plan approval.

If you move outside of our service area, you may enroll in another plan at that time. You do not have to wait until open season to change plans. Contact BENEFEDS at

www.BENEFEDS.gov or call 1-877-888-FEDS (1-877-888-3337), TTY: 711, International: 1-571-730-5942 to change plans.

Rating Areas

Your rates are determined based on where you live. This is called a rating area. If you move, you must update your address through BENEFEDS. Your rates might change because of the move.

Limited Access Areas

If you live in a limited access area and you receive covered services from an out-of-network provider, we will pay in accordance with our plan allowance. You are responsible for any difference between the amount billed and our payment. You can find a list of our limited access areas at www.FederalDentalPlans.com or by contacting us at 855-836-6337.

Alternate Benefit

There are no alternate benefits associated with this plan. The copayment for each listed procedure you receive is the total amount you will owe the dentist.

Section 4 Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Copayment	A copayment is a fixed amount of money you pay directly to the dentist when you receive covered services. Your benefit schedule lists the copayments for each covered procedure. Procedure codes not listed are not covered by this plan. There is also a $10 office visit copay in addition to the listed charge per office visit, not per procedure. Example: In our Standard Plan, you pay $48 for an amalgam – one surface, primary or permanent (ADA Code D2140).
Annual Benefit Maximum	There is no annual benefit maximum limit under this plan.
Lifetime Benefit Maximum	There is no lifetime benefit maximum limit under this plan
In-Network Services	The copayment amounts listed in the benefit schedule along with the $10 office visit copay represent your total cost for in-network services (please note that the office visit copay is charged per visit, not per procedure).
Out-of-Network Services	Benefits under your plan must be received through in-network dentists. There is no coverage for services rendered by an out-of-network provider except for out-of-network emergency services.
Emergency Services	This is an in-network only plan. Services received outside of the network are limited to out-of-area emergency services. You may have emergency services rendered by any licensed dentist when outside of the service area. We will reimburse you for emergency services up to $100 per member per year. Emergency services are defined as “palliative care of injury, toothache, or accident requiring the immediate attention of a dentist or hospital/ambulatory surgical care center.” Services are limited to those procedures not excluded under the plan’s limitations and general exclusions. When traveling overseas, we will authorize emergency services only.
Plan Allowance	The copayments listed in Section 5 and the $10 office visit copay are the only payments you make to the dentist for covered services. There are no calculations based on plan allowances that will result in any additional costs to you.
In-Progress Treatment	In-progress treatment for dependents of retiring active duty service members who were enrolled in the TRICARE Dental Program (TDP) will be covered for the 2027 plan year; regardless of any current plan exclusion for care initiated prior to the enrollee's effective date. This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2027 plan year such as crowns and implants.

Section 5 Dental Services and Supplies
Class A Basic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- All oral evaluations will be considered integral when provided on the same date of service by the same dentist.
- There is no calendar year deductible.
- There is no waiting period for basic services.
- There is no annual benefit maximum.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

- **In-Network:** The copay amount shown in the Benefit Schedule along with a $10 office visit copay (please note that the office visit copay is charged per office visit, not per procedure).
- **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Diagnostic and Treatment Services	Standard	High
D0120 Periodic oral evaluation - established patient	$0	$0
D0140 Limited oral evaluation – problem focused	$0	$0
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0	$0
D0150 Comprehensive oral evaluation – new or established patient	$0	$0
D0160 Detailed and extensive oral evaluation - problem focused, by report	$30	$0
D0180 Comprehensive periodontal evaluation – new or established patient	$0	$0
D0210 Intraoral – comprehensive series of radiographic images	$0	$0
D0220 Intraoral - periapical first radiographic image	$0	$0
D0230 Intraoral - periapical each additional radiographic image	$0	$0
D0240 Intraoral - occlusal radiographic image	$0	$0
D0250 Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0	$0
D0251 Extra-oral posterior dental radiographic image	$0	$0
D0270 Bitewing - single radiographic image	$0	$0
D0272 Bitewings - two radiographic images	$0	$0
D0273 Bitewings - three radiographic images	$0	$0
D0274 Bitewings - four radiographic images	$0	$0
D0277 Vertical bitewings - 7 to 8 radiographic images	$0	$0
D0330 Panoramic radiographic image	$0	$0
D0340 2D cephalometric radiographic image – acquisition, measurement and analysis	$0	$0
D0350 2D oral/facial photographic image obtained intra-orally or extra-orally	$0	$0

Diagnostic and Treatment Services - continued on next page

Diagnostic and Treatment Services (cont.)	Standard	High
D0372 Intraoral tomosynthesis – comprehensive series of radiographic images	$0	$0
D0373 Intraoral tomosynthesis – bitewing radiographic image	$0	$0
D0374 Intraoral tomosynthesis – periapical radiographic image	$0	$0
D0387 Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	$0	$0
D0388 Intraoral tomosynthesis – bitewing radiographic image – image capture only	$0	$0
D0389 Intraoral tomosynthesis – periapical radiographic image – image capture only	$0	$0
D0417 Collection and preparation of saliva sample for laboratory analysis	$0	$0
D0425 Caries susceptibility tests	$0	$0
D0426 Collection, preparation, and analysis of saliva sample - point-of-care	$0	$0
D0470 Diagnostic casts	$0	$0
Preventative Services	**Standard**	**High**
D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	$0	$0
D0601 Caries risk assessment and documentation, with a finding of low risk	$0	$0
D0602 Caries risk assessment and documentation, with a finding of moderate risk	$0	$0
D0603 Caries risk assessment and documentation, with a finding of high risk	$0	$0
D0701 Panoramic radiographic image – image capture only	$0	$0
D0702 2-D cephalometric radiographic image – image capture only	$0	$0
D0703 2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	$0	$0
D0705 Extra-oral posterior dental radiographic image – image capture only	$0	$0
D0706 Intraoral – occlusal radiographic image – image capture only	$0	$0
D0707 Intraoral – periapical radiographic image – image capture only	$0	$0
D0708 Intraoral – bitewing radiographic image – image capture only	$0	$0
D0709 Intraoral – comprehensive series of radiographic images – image capture only	$0	$0
D1110 Prophylaxis - adult	$0	$0
D1110 Prophylaxis - adult **Additional cleaning for all members*	$40	$40
D1120 Prophylaxis - child	$0	$0
D1206 Application of medicament - topical fluoride varnish; full mouth	$0	$0
D1208 Application of medicament - topical fluoride - excluding varnish; full mouth	$0	$0
D1351 Sealant – per tooth	$0	$0
D1353 Sealant repair – per tooth	$0	$0
D1354 Application of caries arresting medicament without surgical intervention - per tooth	$0	$0
D1355 Application of medicament - primary prevention, or remineralization without surgical intervention; per tooth	$0	$0
D1510 Space maintainer – fixed, unilateral – per quadrant	$0	$0
D1516 Space maintainer - fixed - bilateral, maxillary	$0	$0
D1517 Space maintainer - fixed - bilateral, mandibular	$0	$0
D1520 Space maintainer – removable, unilateral – per quadrant	$0	$0

Preventative Services - continued on next page

Preventative Services (cont.)	Standard	High
D1526 Space maintainer - removable - bilateral, maxillary	$0	$0
D1527 Space maintainer - removable - bilateral, mandibular	$0	$0
D1551 Re-cement or re-bond bilateral space maintainer - maxillary	$0	$0
D1552 Re-cement or re-bond bilateral space maintainer – mandibular	$0	$0
D1553 Re-cement or re-bond unilateral space maintainer – per quadrant	$0	$0
D1556 Removal of fixed unilateral space maintainer - per quadrant	$0	$0
D1557 Removal of fixed bilateral space maintainer – maxillary	$0	$0
D1558 Removal of fixed bilateral space maintainer - mandibular	$0	$0
D1575 Distal shoe space maintainer - fixed, unilateral - per quadrant	$0	$0
Additional Procedures Covered as Basic Services	**Standard**	**High**
D9110 Palliative treatment of dental pain – per visit	$38	$35
D9995 Teledentistry – synchronous; real-time encounter	$0	$0
D9996 Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0	$0
Not covered: • *Plaque control programs* • *Oral hygiene instruction* • *Dietary instructions* • *Sealants for teeth other than permanent molars* • *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss* • *Any exclusions or limitations listed under Section 7 of this plan document*		

Prevention Rewards

Prevention Rewards Program

Each family member enrolled with Dominion National who receives two cleanings during the plan year will be reimbursed for their $10 office visit copayments made to the dentist at the time of service (a total reimbursement of $20 per family member).* Checks are sent monthly to enrollees who qualify.

*If you take advantage of the additional third cleaning offered at a reduced fee, the additional cleaning will not be part of the Prevention Rewards program (payments are limited to two cleanings). For enrollees participating with FSAFEDS, Dominion may coordinate the reimbursement through the FSA.

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period for intermediate services.
- There is no annual benefit maximum.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

- **In-Network:** The copay amount shown in the Schedule of Benefits along with a $10 office visit copay (please note that the office visit copay is charged per office visit, not per procedure).
- **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Minor Restorative Services	Standard	High
D2140 Amalgam – one surface, primary or permanent	$48	$0
D2150 Amalgam – two surfaces, primary or permanent	$62	$0
D2160 Amalgam – three surfaces, primary or permanent	$75	$0
D2161 Amalgam – four or more surfaces, primary or permanent	$88	$0
D2330 Resin-based composite – one surface, anterior	$55	$16
D2331 Resin-based composite – two surfaces, anterior	$67	$20
D2332 Resin-based composite – three surfaces, anterior	$81	$24
D2335 Resin-based composite – four or more surfaces (anterior)	$83	$24
D2390 Resin-based composite crown - direct	$125	$37
D2391 Resin-based composite – one surface, posterior	$61	$18
D2392 Resin-based composite – two surfaces, posterior	$78	$23
D2393 Resin-based composite – three surfaces, posterior	$96	$28
D2394 Resin-based composite – four or more surfaces, posterior	$110	$33
D2610 Inlay - porcelain/ceramic - one surface	$315	$202
D2620 Inlay - porcelain/ceramic - two surfaces	$288	$183
D2630 Inlay - porcelain/ceramic - three or more surfaces	$423	$252
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$38	$12
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core	$38	$12
D2920 Re-cement or re-bond crown	$38	$12
D2921 Reattachment of tooth fragment, incisal edge or cusp	$71	$23
D2930 Prefabricated stainless steel crown – primary tooth	$100	$70
D2931 Prefabricated stainless steel crown – permanent tooth	$100	$70
D2951 Pin retention – per tooth, in addition to restoration	$18	$5

Endodontic Services	Standard	High
D3110 Pulp cap – direct (excluding final restoration)	$29	$8
D3120 Pulp cap – indirect (excluding final restoration)	$28	$8
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$72	$21
D3221 Pulpal debridement, primary and permanent teeth	$76	$22
D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$74	$28
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$81	$28
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$96	$28
D3355 Pulpal regeneration - initial visit	$170	$109
D3356 Pulpal regeneration - interim medication replacement	$156	$156
D3357 Pulpal regeneration - completion of treatment	$200	$150
Periodontal Services	**Standard**	**High**
D4341 Periodontal scaling and root planing - four or more teeth per quadrant	$105	$31
D4342 Periodontal scaling and root planing - one to three teeth per quadrant	$64	$23
D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$48	$32
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$25	$7
D4910 Periodontal maintenance	$56	$16
Prosthodontic Services	**Standard**	**High**
D5410 Adjust complete denture – maxillary	$30	$9
D5411 Adjust complete denture – mandibular	$30	$9
D5421 Adjust partial denture – maxillary	$30	$9
D5422 Adjust partial denture – mandibular	$30	$9
D5511 Repair complete denture base, mandibular	$56	$20
D5512 Repair complete denture base, maxillary	$56	$20
D5520 Replace missing or broken teeth – complete denture – per tooth	$56	$20
D5611 Repair resin partial denture base, mandibular	$56	$20
D5612 Repair resin partial denture base, maxillary	$56	$20
D5621 Repair cast partial framework, mandibular	$56	$20
D5622 Repair cast partial framework, maxillary	$56	$20
D5630 Repair or replace broken retentive clasping materials – per tooth	$81	$24
D5640 Replace missing or broken teeth – partial denture – per tooth	$56	$20
D5650 Add tooth to existing partial denture – per tooth	$56	$20
D5660 Add clasp to existing partial denture - per tooth	$56	$20
D5670 Replace all teeth and acrylic on cast metal framework (maxillary)	$326	$109
D5671 Replace all teeth and acrylic on cast metal framework (mandibular)	$320	$109
D5710 Rebase complete maxillary denture	$184	$55
D5711 Rebase complete mandibular denture	$184	$55

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)	Standard	High
D5720 Rebase maxillary partial denture	$184	$55
D5721 Rebase mandibular partial denture	$184	$55
D5725 Rebase hybrid prosthesis	$184	$55
D5730 Reline complete maxillary denture (direct)	$111	$33
D5731 Reline complete mandibular denture (direct)	$111	$33
D5740 Reline maxillary partial denture (direct)	$111	$33
D5741 Reline mandibular partial denture (direct)	$111	$33
D5750 Reline complete maxillary denture (indirect)	$165	$49
D5751 Reline complete mandibular denture (indirect)	$165	$49
D5760 Reline maxillary partial denture (indirect)	$165	$49
D5761 Reline mandibular partial denture (indirect)	$165	$49
D5765 Soft liner for complete or partial removable denture – indirect	$50	$15
D5850 Tissue conditioning, maxillary	$56	$16
D5851 Tissue conditioning, mandibular	$56	$16
D6930 Re-cement or re-bond fixed partial denture	$58	$17
D6980 Fixed partial denture repair necessitated by restorative material failure	$172	$124
Oral Surgery	**Standard**	**High**
D7111 Extraction, coronal remnants – primary tooth	$45	$36
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$58	$47
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$107	$86
D7220 Removal of impacted tooth – soft tissue	$132	$106
D7230 Removal of impacted tooth – partially bony	$170	$136
D7240 Removal of impacted tooth – completely bony	$200	$160
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications	$220	$178
D7250 Removal of residual tooth roots (cutting procedure)	$112	$90
D7251 Coronectomy – intentional partial tooth removal, impacted teeth only	$112	$90
D7252 Partial extraction for immediate implant placement	$112	$90
D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$171	$137
D7280 Exposure of an unerupted tooth	$182	$63
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$96	$28
D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$68	$24
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$114	$34
D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$83	$28
D7471 Removal of lateral exostosis (maxilla or mandible)	$206	$61
D7509 Marsupialization of odontogenic cyst	$400	$360

Oral Surgery - continued on next page

Oral Surgery (cont.)	Standard	High
D7510 Incision and drainage of abscess – intraoral soft tissue	$82	$24
D7910 Suture of recent small wounds up to 5 cm	$34	$10
D7921 Collection and application of autologous blood concentrate product	$40	$35
D7971 Excision of pericoronal gingiva	$77	$23
D7979 Non-surgical sialolithotomy	$38	$35
D7999 Unspecified oral surgery procedure, by report	$0	$0

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period for major services.
- There is no annual benefit maximum.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

- **In-Network:** The copay amount shown in the Schedule of Benefits along with a $10 office visit copay (please note that the office visit copay is charged per office visit, not per procedure).
- **Out-of-Network:** In full for all charges. There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Major Restorative Services	Standard	High
D2510 Inlay – metallic – one surface	$385	$247
D2520 Inlay – metallic – two surfaces	$444	$282
D2530 Inlay – metallic – three or more surfaces	$487	$290
D2542 Onlay – metallic – two surfaces	$497	$338
D2543 Onlay – metallic – three surfaces	$544	$363
D2544 Onlay – metallic – four or more surfaces	$559	$380
D2740 Crown – porcelain/ceramic	$583	$417
D2750 Crown – porcelain fused to high noble metal	$555	$380
D2751 Crown - porcelain fused to predominantly base metal	$555	$380
D2752 Crown – porcelain fused to noble metal	$548	$380
D2780 Crown – ¾ cast high noble metal	$519	$260
D2781 Crown - 3/4 cast predominantly base metal	$519	$260
D2782 Crown – ¾ cast noble metal	$519	$260
D2783 Crown – ¾ porcelain/ceramic	$549	$290
D2790 Crown – full cast high noble metal	$543	$366
D2791 Crown - full cast predominantly base metal	$543	$366
D2792 Crown – full cast noble metal	$543	$366
D2794 Crown – titanium and titanium alloys	$543	$366
D2950 Core buildup, including any pins when required	$120	$90
D2954 Prefabricated post and core in addition to crown	$146	$112
D2980 Crown repair necessitated by restorative material failure	$107	$72
D2981 Inlay repair necessitated by restorative material failure	$107	$72
D2982 Onlay repair necessitated by restorative material failure	$107	$72
D2983 Veneer repair necessitated by restorative material failure	$107	$72

Major Restorative Services - continued on next page

Major Restorative Services (cont.)	Standard	High
D2990 Resin infiltration of incipient smooth surface lesions	$28	$12
Endodontic Services	**Standard**	**High**
D3310 Endodontic therapy, anterior tooth (excluding final restoration)	$332	$260
D3320 Endodontic therapy, premolar tooth (excluding final restoration)	$408	$332
D3330 Endodontic therapy, molar tooth (excluding final restoration)	$535	$416
D3346 Retreatment of previous root canal therapy - anterior	$436	$290
D3347 Retreatment of previous root canal therapy - premolar	$513	$371
D3348 Retreatment of previous root canal therapy - molar	$617	$438
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$170	$109
D3352 Apexification/recalcification – interim medication replacement	$139	$139
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$231	$231
D3410 Apicoectomy - anterior	$396	$238
D3421 Apicoectomy - premolar (first root)	$432	$268
D3425 Apicoectomy - molar (first root)	$489	$283
D3426 Apicoectomy (each additional root)	$163	$112
D3428 Bone graft in conjunction with periradicular surgery – per tooth, single site	$208	$208
D3429 Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	$105	$105
D3430 Retrograde filling – per root	$120	$81
D3431 Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$174	$174
D3432 Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	$588	$379
D3450 Root amputation – per root	$244	$156
D3471 Surgical repair of root resorption – anterior	$396	$238
D3472 Surgical repair of root resorption – premolar	$432	$268
D3473 Surgical repair of root resorption – molar	$489	$283
D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$396	$238
D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$432	$268
D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$489	$283
D3920 Hemisection (including any root removal), not including root canal therapy	$189	$145
D3921 Decoronation or submergence of an erupted tooth	$100	$64

Periodontal Services	Standard	High
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$290	$205
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$77	$70
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$40	$30
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$341	$257
D4241 Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$234	$74
D4249 Clinical crown lengthening – hard tissue	$365	$341
D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$551	$422
D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$404	$282
D4268 Surgical revision procedure, per tooth	$522	$258
D4270 Pedicle soft tissue graft procedure	$407	$381
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$526	$474
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$480	$394
D4276 Combined connective tissue and pedicle graft, per tooth	$581	$432
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$490	$420
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$100	$80
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$475	$305
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$427	$274
D4286 Removal of non-resorbable barrier	$100	$90
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$78	$64
D4999 Unspecified periodontal procedure, by report	$45	$30
Prosthodontic Services	**Standard**	**High**
D5110 Complete denture – maxillary	$598	$455
D5120 Complete denture – mandibular	$598	$455
D5130 Immediate denture – maxillary	$653	$511
D5140 Immediate denture – mandibular	$653	$511
D5211 Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$477	$306
D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$477	$306

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)	Standard	High
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$661	$549
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$661	$549
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$467	$315
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$467	$315
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$661	$525
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$661	$525
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$693	$661
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$693	$661
D5227 Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$693	$661
D5228 Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$693	$661
D5282 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$393	$281
D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$393	$281
D5284 Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	$393	$281
D5286 Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	$393	$281
D5876 Add metal substructure to acrylic complete denture – per arch	$58	$17
D6010 Surgical placement of implant body: endosteal implant	$1073	$830
D6011 Surgical access to an implant body (second stage implant surgery)	$200	$200
D6013 Surgical placement of mini implant	$431	$277
D6040 Surgical placement: eposteal implant	$953	$612
D6049 Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	$64	$23
D6050 Surgical placement: transosteal implant	$1830	$1176
D6055 Connecting bar – implant supported or abutment supported	$720	$720
D6056 Prefabricated abutment – includes modification and placement	$312	$220
D6057 Custom fabricated abutment – includes placement	$438	$315
D6058 Abutment supported porcelain/ceramic crown	$692	$547
D6059 Abutment supported porcelain fused to metal crown (high noble metal)	$629	$544
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)	$584	$485
D6061 Abutment supported porcelain fused to metal crown (noble metal)	$625	$512

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)	Standard	High
D6062 Abutment supported cast metal crown (high noble metal)	$645	$536
D6063 Abutment supported cast metal crown (predominantly base metal)	$642	$477
D6064 Abutment supported cast metal crown (noble metal)	$715	$499
D6065 Implant supported porcelain/ceramic crown	$708	$572
D6066 Implant supported crown – porcelain fused to high noble alloys	$713	$575
D6067 Implant supported crown – high noble alloys	$738	$556
D6068 Abutment supported retainer for porcelain/ceramic FPD	$664	$507
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$652	$542
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$653	$447
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$700	$453
D6072 Abutment supported retainer for cast metal FPD (high noble metal)	$632	$507
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)	$594	$481
D6074 Abutment supported retainer for cast metal FPD (noble metal)	$699	$487
D6075 Implant supported retainer for ceramic FPD	$778	$562
D6076 Implant supported retainer for FPD – porcelain fused to high noble alloys	$702	$529
D6077 Implant supported retainer for metal FPD – high noble alloys	$810	$560
D6080 Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$44	$39
D6081 Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$64	$23
D6090 Repair of implant/abutment supported prosthesis	$362	$233
D6091 Replacement of replaceable part of semi-precision attachment of implant/abutment retained prosthesis, per attachment	$34	$22
D6092 Re-cement or re-bond implant/abutment supported crown	$44	$39
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture	$68	$49
D6094 Abutment supported crown – titanium and titanium alloys	$553	$355
D6100 Surgical removal of implant body	$182	$155
D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$477	$307
D6104 Bone graft at time of implant placement	$281	$180
D6105 Removal of implant body not requiring bone removal or flap elevation	$91	$78
D6110 Implant /abutment retained removable denture for edentulous arch - maxillary	$1346	$865
D6111 Implant /abutment retained removable denture for edentulous arch - mandibular	$1260	$809
D6112 Implant /abutment retained removable denture for partially edentulous arch - maxillary	$1238	$795
D6113 Implant /abutment retained removable denture for partially edentulous arch - mandibular	$1162	$746
D6114 Implant /abutment supported fixed denture for edentulous arch – maxillary	$1346	$865
D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular	$1260	$809
D6116 Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$958	$615

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)	Standard	High
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$958	$615
D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$56	$16
D6191 Placement of semi-precision abutment - implant body	$274	$176
D6192 Semi-precision attachment – placement	$274	$176
D6194 Abutment supported retainer crown for FPD – titanium and titanium alloys	$741	$476
D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$55	$16
D6210 Pontic – cast high noble metal	$538	$366
D6211 Pontic - cast predominantly base metal	$543	$366
D6212 Pontic – cast noble metal	$543	$366
D6214 Pontic – titanium and titanium alloys	$543	$366
D6240 Pontic – porcelain fused to high noble metal	$530	$380
D6241 Pontic - porcelain fused to predominantly base metal	$459	$380
D6242 Pontic – porcelain fused to noble metal	$517	$380
D6245 Pontic – porcelain/ceramic	$585	$417
D6280 Implant maintenance procedures when a full arch removable implant/abutment retained denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch	$250	$185
D6545 Retainer – cast metal for resin bonded fixed prosthesis	$224	$175
D6548 Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$396	$256
D6601 Retainer inlay – porcelain/ceramic, three or more surfaces	$354	$228
D6604 Retainer inlay – cast predominantly base metal, two surfaces	$236	$152
D6605 Retainer inlay – cast predominantly base metal, three or more surfaces	$302	$194
D6613 Retainer onlay – cast predominantly base metal, three or more surfaces	$332	$213
D6740 Retainer crown – porcelain/ceramic	$600	$417
D6750 Retainer crown – porcelain fused to high noble metal	$555	$380
D6751 Retainer crown - porcelain fused to predominantly base metal	$542	$380
D6752 Retainer crown – porcelain fused to noble metal	$555	$380
D6780 Retainer crown – 3/4 cast high noble metal	$519	$260
D6781 Retainer crown - 3/4 cast predominantly base metal	$519	$260
D6782 Retainer crown – 3/4 cast noble metal	$519	$260
D6783 Retainer crown – 3/4 porcelain/ceramic	$549	$290
D6790 Retainer crown – full cast high noble metal	$543	$366
D6791 Retainer crown - full cast predominantly base metal	$543	$366
D6792 Retainer crown – full cast noble metal	$543	$366
D6794 Retainer crown - titanium and titanium alloys - *An alternate benefit will be provided on posterior teeth*	$543	$366
D9932 Cleaning and inspection of removable complete denture, maxillary	$24	$24
D9933 Cleaning and inspection of removable complete denture, mandibular	$24	$24
D9934 Cleaning and inspection of removable partial denture, maxillary	$24	$24

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)	Standard	High
D9935 Cleaning and inspection of removable partial denture, mandibular	$24	$24
D9936 Cleaning and inspection of occlusal guard - per appliance	$24	$24
D9999 Unspecified adjunctive procedure, by report	$0	$0
Not covered: • *Any exclusions or limitations listed under Section 7 of this plan document*	-	-

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- There is no waiting period for orthodontic services.
- There is no lifetime maximum for orthodontic services.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

- **In-Network:** The copay amount shown in the Schedule of Benefits along with a $10 office visit copay (please note that the office visit copay is charged per office visit, not per procedure).
- **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.

Orthodontic Services	Standard	High
D8010 Limited orthodontic treatment of the primary dentition	$1045	$1045
D8020 Limited orthodontic treatment of the transitional dentition	$1236	$1236
D8030 Limited orthodontic treatment of the adolescent dentition	$1664	$1664
D8040 Limited orthodontic treatment of the adult dentition	$1664	$1664
D8070 Comprehensive orthodontic treatment of the transitional dentition - *Invisalign - 15% discount from participating dentist's UCR fee*	$3304	$3304
D8080 Comprehensive orthodontic treatment of the adolescent dentition - *Invisalign - 15% discount from participating dentist's UCR fee*	$3422	$3422
D8090 Comprehensive orthodontic treatment of the adult dentition - *Invisalign - 15% discount from participating dentist's UCR fee*	$3658	$3658
D8210 Adjunctive orthodontic therapy - removable appliance	$620	$620
D8220 Adjunctive orthodontic therapy - fixed appliance	$630	$630
D8660 Pre-orthodontic treatment examination to monitor growth and development	$78	$78
D8670 Periodic orthodontic treatment visit	$118	$118
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$157	$157
D8681 Removable orthodontic retainer adjustment	$31	$31

Orthodontic Services - continued on next page

Orthodontic Services (cont.)	Standard	High
Not covered: • *Any exclusions or limitations listed under Section 7 of this plan document*	x	x

General Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- There is no calendar year deductible.
- The is no annual benefit maximum.
- **See Section 7 of this brochure for plan limitations**.
- Not covered:
  - Oral sedation
  - Any exclusions or limitations listed under Section 7 of this plan document

You Pay:

- **In-Network:** The copayment shown in the Benefit Schedule along with a $10 office visit copay (please note that the office visit copay is charged per office visit, not per procedure).
- **Out-of-Network: In full for all charges.** There are no out-of-network benefits available except for emergency services when the services of an in-network provider are not available.
- Not covered:
  - Oral sedation
  - Any exclusions or limitations listed under Section 7 of this plan document

Anesthesia Services	Standard	High
D9219 Evaluation for moderate sedation, deep sedation or general anesthesia	$0	$0
D9222 Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	$76	$76
D9223 Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	$76	$76
D9224 Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof	$76	$76
D9225 Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof	$76	$76
D9230 Administration of nitrous oxide	$31	$24
D9246 Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof	$76	$76
D9247 Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof	$76	$76

Intravenous Sedation	Standard	High
D9239 Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	$90	$81
D9243 Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof	$90	$81
Consultations	**Standard**	**High**
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0	$0
D9311 Consultation with a medical health care professional	$0	$0
Office Visits	**Standard**	**High**
Office visit	$10	$10
D9440 Office visit – after regularly scheduled hours	$10	$10
D9986 Missed appointment	$50	$50
Medications	**Standard**	**High**
D9610 Therapeutic parenteral drug, single administration	$31	$20
D9612 Therapeutic parenteral drugs, two or more administrations, different medications	$48	$31
D9613 Infiltration of sustained release therapeutic drug, per quadrant	$190	$190
Post Surgical Services	**Standard**	**High**
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report	$43	$42
Miscellaneous Services	**Standard**	**High**
D9941 Fabrication of athletic mouthguard	$65	$42
D9943 Occlusal guard adjustment	$43	$42
D9944 Occlusal guard - hard appliance, full arch	$285	$191
D9945 Occlusal guard - soft appliance, full arch	$285	$191
D9946 Occlusal guard - hard appliance, partial arch	$285	$191
D9953 Reline custom sleep apnea appliance (indirect)	$175	$158
D9972 External bleaching – per arch – performed in office	15% Discount	15% Discount
D9973 External bleaching – per tooth	15% Discount	15% Discount
D9974 Internal bleaching – per tooth	$131	$84
D9975 External bleaching for home application, per arch; includes materials and fabrication of custom trays	15% Discount	15% Discount

Section 6 International Services and Supplies

International Claims Payment	This plan provides a benefit for emergency services when overseas. Emergency services are defined as "palliative care of injury, toothache, or accident requiring the immediate attention of a dentist or hospital/ambulatory surgical care center." Services are limited to those procedures not excluded under Plan Limitations and Exclusions. We will reimburse you for emergency services up to $100 per member per year.
Finding an International Provider	This plan provides a benefit for international emergency services when services are received from a licensed dentist. The Dominion National network does not extend outside of the United States. You have the right to choose any licensed dental practitioner; you do not need to contact Dominion first. **Note:** Because international claims do not have the consideration of stateside cost containment, members must be cautious to guard against inappropriate/excessive services.
Filing International Claims	The following should be provided when submitting a claim for International emergency services: • Name of country where services were received • American Dental Association procedure codes • Translation of language to English • Translation into US currency or accurate day rate • Tooth number(s) and/or quadrants • Date(s) of service • Dentist name
Customer Service Website and Phone Numbers	Our plan website is https://www.FederalDentalPlans.com. You may also contact us by phone at 855-836-6337.

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.**

We do not cover the following:

Plan Exclusions

- Services which are covered under Medicare, worker's compensation or employer's liability laws.
- Services which are not necessary for the patient's dental health as determined by the Plan.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
- Oral surgery requiring the setting of fractures or dislocations.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared.
- Replacement due to loss or theft of prosthetic appliance.
- Procedures not listed as covered benefits under this Plan.
- Services related to the treatment of TMD (Temporomandibular Disorder).
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
- Plaque control programs, oral hygiene instruction, and dietary instructions.
- Oral sedation.

Plan Limitations

- Two (2) evaluations are covered per calendar year including a maximum of one (1) comprehensive evaluation. Two (2) oral evaluation for a patient under three years of age and counseling with primary caregiver per calendar year. All oral evaluations will be considered integral when provided on the same date of service by the same dentist.
- One (1) problem focused exam is covered per calendar year, per patient.
- Two (2) teeth cleanings (prophylaxis) are covered per calendar year, per patient (one (1) additional cleaning is covered for all members at the listed copayment). Periodontal scaling in the presence of gingival inflammation is considered to be a routine prophylaxis and paid as such.
- Two (2) topical fluorides or fluoride varnishes are covered per calendar year, per patient.
- Two (2) bitewing x-rays are covered per calendar year, per patient.
- One (1) set of full mouth x-rays or panoramic film is covered every three (3) years, per patient.
- One (1) sealant or caries preventive medicament application per tooth is covered per 36 months, up to age 18 (limited to permanent 1st and 2nd molars). Sealants with a restoration on same date of service are considered integral.
- Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
- Replacement of a bridge, crown or denture is covered if it is more than five (5) years from the date of original placement.
- Crown, implant and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown, implant or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.

- One (1) relining and rebasing of dentures is covered every 36 months, per patient.
- Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
- Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
- One (1) root planing or scaling is covered every 24 months per quadrant, per patient. Periodontal scaling and root planing provided within 24 months of periodontal scaling and root planing, or periodontal surgical procedures, in the same area of the mouth is not covered.
- Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation and in lieu of a covered D1110 Prophylaxis - adult/D1120 Prophylaxis - child limited to once per two years.
- One (1) full mouth debridement is covered per lifetime, per patient.
- Procedure Code D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth is limited to one (1) benefit per tooth for three (3) teeth per quadrant or a total of 12 teeth for all four (4) quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater.
- One (1) periodontal surgery of any type, including any associated material, is covered every 36 months per quadrant or surgical site.
- Periodontal maintenance after active therapy is covered two (2) times per calendar year, within 24 months after definitive periodontal therapy.
- Stainless steel crowns (D2930 Prefabricated stainless steel crown - primary tooth, D2931 Prefabricated stainless steel crown - permanent tooth) are covered through age 14, or when placed as a result of accidental injury and one per tooth, per lifetime.
- Onlays, crowns, and posts and cores for members 12 years of age or younger are excluded from coverage, unless pre-approved by the Plan.
- Cast posts and cores (D2952 Post and core in addition to crown, indirectly fabricated) are processed as an alternate benefit of a prefabricated post and core. Posts are eligible only when provided as part of a crown buildup or implant and are considered integral to the buildup or implant.
- Fixed partial dentures, buildups and posts and cores for members under 16 years of age are not covered unless approved by the Plan.
- Surgical periodontal procedures or scaling and root planing in the same area of the mouth within 24 months of a gingival flap procedure are not covered.
- Osseous surgery is not covered when provided within 24 months of osseous surgery in the same area of the mouth.
- Surgical revision procedure (D4268 Surgical revision procedure, per tooth) is considered integral to all other periodontal procedures.
- One (1) scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two (2) years.
- Removal of impacted third molars in patients under age 15 and over age 30 is not covered unless approved by the Plan.
- Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions
- Occlusal guards are covered by report for patients 13 years of age or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.
- Athletic mouth guards are limited to one (1) per 12 consecutive month period.
- The Invisalign system is a discounted benefit that applies to D8070 Comprehensive orthodontic treatment of the transitional dentition, D8080 Comprehensive orthodontic treatment of the adolescent dentition, and D8090 Comprehensive orthodontic treatment of the adult dentition. Additional costs incurred will become the patient's responsibility.

- Teledentistry, synchronous (D9995 Teledentistry – synchronous; real-time encounter) or asynchronous (D9996 Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review), must be accompanied by a covered procedure.
- Crowns are only covered in the event of extensive decay or severe fracture; crowns are not covered if they are for preventive purposes.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

For in-network services, there are no claims for you to file.

This plan does not offer an out-of-network benefit. If you see an out-of-network provider for emergency services, the claim (a standard ADA claim form) should be submitted to:

Dominion National
P.O. Box 211424
Eagan, MN 55121

International Claims

If you see an international dentist for emergency services, a dental claim form should be completed for each patient in full and accompanied by fully itemized bills. The claim form should be submitted in English, but it is not necessary for you to convert currency. If a claim is submitted with non-U.S. currency, the currency submitted will be converted as of the date of service, using the website http://www.xe.com.

You can print a claim form from our website at www.DominionNational.com.

Since the claim will not be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. If you need assistance in completing the claim form, please call Dominion Customer Service at 855-836-6337.

Dominion National – Special Handling
P.O. Box 211424
Eagan, MN 55121

Deadline for Filing Your Claim

The plan must receive written proof of loss within 180 days of treatment. Failure to provide proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one year from the time proof is otherwise required. Instructions for submitting proof of loss to the plan can be found on the Membership Identification Card.

Disputed Claims Process

Follow this disputed claims process, if you disagree with our decision on your claim or request for services. **The FEDVIP law does not provide a role for OPM to review disputed claims.**

Disputed Claim Steps

1. Ask us in writing to reconsider our initial decision. Please submit with your appeal any pertinent information related to the claim including written comments from the treating dentist, supporting documents and dental records. Your appeal must be filed within 180 days of receipt of the initial denial of the claim(s).
2. Send your appeal to Grievances and Appeals c/o Dominion National, 251 18th Street South, Suite 900, Arlington, VA 22202 or fax to 703.518.4450. We will conduct a thorough review of your appeal and provide a written response within 60 days from the date of receipt. If additional time is needed to complete our review, we will notify you in writing.
3. If the dispute is not resolved through the reconsideration process, you may request a second review within 30 days of the first review of the decision. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

4. If you do not agree with our final decision, after the internal appeal process is exhausted, you may request an independent third party, mutually agreed upon by Dominion National and OPM, to review the decision. You must file the appeal in writing to Dominion National at the address above. The appeal should include the appropriate written comments from the treating dentist, supporting documents and dental records relating to the claim(s). The independent third party reviewer will thoroughly review the appeal and provide the decision to Dominion National who will respond to you in writing within 60 days from the date we receive the request. The decision of the independent third party is binding and is the final review of your claim.

Section 9 Definitions of Terms We Use in This Brochure

Annual Benefit Maximum	The maximum annual benefit that you can receive per person. This plan does not have an annual benefit maximum.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C Services	Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
Class D Services	Orthodontic services.
Copay	Copay or copayment is a fixed amount of money you pay directly to the dentist when you receive covered services.
Emergency Services	Palliative care of injury, toothache, or accident requiring the immediate attention of a dentist or hospital/ambulatory surgical care center.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	The standards set by the American Dental Association or which are customarily used for dental care. Dominion National reserves the right to determine the level of necessary treatment.
In-Progress Treatment	Dental services that initiated in 2026 that will be completed in 2027.
Plan Allowance	The amount we use to determine our payment for out-of-network services.
Preexisting Condition	Any disease or condition of the teeth or supporting structures which existed on the effective date of coverage.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

We/Us	Dominion National
You	Enrollee or eligible family member.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 855-836-6337 and explain the situation.
- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless they are disabled and incapable of self- support).

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; please review the individual sections of this brochure, for more detail.
- If you want to enroll or change your enrollment in this plan, please visit https ://www. BENEFEDS.gov or call 1-877-888-FEDS (1-877-888-3337), TTY: 711, International: 1-571-730-5942.

Benefit	You Pay:	
High Option Benefits	**Standard**	**High**
Class A (Basic) Services – preventive and diagnostic	Copayment (Approximately 0%)	Copayment (Approximately 0%)
Class B (Intermediate) Services – includes minor restorative services	Copayment (Approximately 28%)	Copayment (Approximately 11%)
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	Copayment (Approximately 37%)	Copayment (Approximately 27%)
Class D Services – orthodontic No Lifetime Maximum No Waiting Period	Copayment (Approximately 56%)	Copayment (Approximately 56%)

Notes

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Rate Information

How to find your monthly and bi-weekly rates:

- In the first chart below, look up your state or zip code to determine your Rating Area
- In the second chart below, match your Rating Area to your enrollment type for a standard option plan
- In the third chart below, match your Rating Area to your enrollment type for a high option plan

Premium Rating Areas by State/Zip Code (first three digits)								
State	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**
DC	Entire State	2	MD	Rest of State	2	PA	Rest of State	1
DE	Entire State	3	NJ	080-084	3	VA	201, 205	2
MD	215, 218	1	PA	172-174	2	VA	220-227	2
MD	219	3	PA	189-196	3	VA	230-238	2

Standard & High Rates

Rating Area	Standard - Bi-Weekly			Standard - Monthly		
	Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
1	**$6.03**	**$12.05**	**$18.08**	**$13.07**	**$26.11**	**$39.17**
2	**$7.71**	**$15.42**	**$23.14**	**$16.71**	**$33.41**	**$50.14**
3	**$8.87**	**$17.73**	**$26.60**	**$19.22**	**$38.42**	**$57.63**

Rating Area	High - Bi-Weekly			High - Monthly		
	Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
1	**$10.17**	**$20.34**	**$30.51**	**$22.04**	**$44.07**	**$66.11**
2	**$11.28**	**$22.57**	**$33.85**	**$24.44**	**$48.90**	**$73.34**
3	**$15.01**	**$30.03**	**$45.04**	**$32.52**	**$65.07**	**$97.59**