DOMINION®
NATIONAL

A Better Path to Benefits

Dominion National recognizes that you're a unique individual and we've designed plans and programs that work for you. We seek a better way to serve you through customized plans and exceptional service so that you can focus on what makes you extraordinary and fulfilled.

WE WORK FOR THE BENEFIT OF OUR MEMBERS, DELIVERING:

EXTENSIVE NETWORKS[2]

Choice PPO network offers access to over 350,000 dentists nationally.[1,3]

Elite PPO and Elite ePPO networks provide unmatched flexibility and lower out-of-pocket costs.

Select Plan network is one of the largest in the Mid-Atlantic region.[3,4]

To find a participating provider, please visit **DominionNational.com.**

SECURE ONLINE ACCESS

Access your digital ID card, find a provider and more through secure online resources.

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LIVE CHAT SUPPORT
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Eligibility and claim information are available for members, benefit administrators and dentists.

VALUE-ADDED BENEFITS

HEARING DISCOUNT PROGRAM
amplifonusa.com/dn
Access to discounts on hearing aids and services.[5]

DIGIBITE TELEDENTISTRY APP
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Receive a dental consultation without leaving your home or office!

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1 Dominion National Internal Performance Report, 2022.
2 Networks and products vary by state. Check availability on your state marketplace.
3 Participating providers are subject to change.
4 Managed care plan with exclusive network, fixed member copayments, no annual maximum dollar limits, no waiting periods and no deductibles. In New Jersey, Select Plans are available in Camden, Cumberland and Gloucester counties only. Dominion National Network Analysis Report, 2023. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.
5 Visit amplifonusa.com/dn for full details. Hearing services are administered by Amplifon Hearing Health Care Corp.

P.O. Box 21522; Eagan, MN 55121-0522

The dental plan is underwritten by Dominion Dental Services, Inc. (hereinafter referred to as "Dominion").

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (DE) Coverage Schedule, Limitations and Exclusions for Pediatric Services

- Coverage continues through end of the year in which the Member turns 19 -

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	0%	None

Annual Deductible	In-Network	Out-of-Network
Single Child	$50	$50
Two or More Children	$100	$100
Applies To	Class 2 and Class 3	Class 2 and Class 3

- Each member must pay the deductible amount for dental services before the plan will begin to cover the member's dental procedures. The deductible is combined for all applicable services for each calendar year per pediatric member - maximum $100 for pediatric members.

Out-of-Pocket Maximums	In-Network	Out-of-Network
Single Child	$400	N/A
Two or More Children	$800	N/A

- The annual out-of-pocket maximum applies to all covered services for medically necessary treatment.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, prior review is required.

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

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	One evaluation (D0120, D0145, D0150 or D0160) per six (6) months	100%	None	No	80%	None	No
1	Limited evaluation or re-evaluation, problem focused	One (D0140 or D0170) per twelve (12) months	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months	100%	None	No	80%	None	No
1	Fluoride treatment	One per six (6) months	100%	None	No	80%	None	No
1	Bitewing x-rays	Four films per six (6) month	100%	None	No	80%	None	No
1	Periapical x-rays	Not on the same date of service as a panoramic radiograph	100%	None	No	80%	None	No
1	Full mouth x-ray or panoramic film	One per 36 months	100%	None	No	80%	None	No
1	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Space maintainer	One fixed space maintainer (D1510, D1516, D1517) per 5 years, per arch to age 14, to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer (cannot be billed by the provider or practice that placed the appliance); one distal shoe space maintainer (D1575), fixed, unilateral per lifetime.	100%	None	No	80%	None	No
1	Sealants	One per tooth per 60 months, to age 16 (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	100%	None	No	80%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	80%	None	No
2	Amalgam and composite fillings	One per tooth per surface every 24 months (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations); sedative fillings when not billed on the same day as a normal restoration	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	80%	None	Yes	60%	None	Yes
2	Crown build-up	Coverage for non-vital teeth	80%	None	Yes	60%	None	Yes
2	Post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	80%	None	Yes	60%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
2	Prefabricated crowns	One per tooth, per 60 months	80%	None	Yes	60%	None	Yes
2	Temporary crowns for a fractured tooth		80%	None	Yes	60%	None	Yes
2	Palliative treatment of dental pain – per visit	Only if no services other than exam and x-rays were performed on the same date of service	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intravenous and nonintravenous sedation	Maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure code D9230, D9239 or D9243; intravenous conscious sedation is not covered with procedure code D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure code D9222, D9223 or D9230; analgesia (nitrous oxide) is not covered with procedure code D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	80%	None	Yes	60%	None	Yes
2	Occlusal guard	One per 24 months with covered surgery	80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay, crown		80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth except the surgical removal of 3rd molars	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root or partial tooth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty, limited to ages 14-18	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Excision of periocoronal gingiva or hyperplastic tissue and excision of oral tissue for biopsy, limited to ages 14-18	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization; tooth transplantation	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Incision and drainage of an abscess or cyst, marsupialization of odontogenic cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Biopsy of oral tissue (D7285, D7286)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Mobilization of erupted or malpositioned tooth, covered for all teeth except 3rd molars	80%	None	Yes	60%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
2	Oral surgery, including postoperative care for:	Placement of device to facilitate eruption of impacted tooth (indicate if orthodontia related)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Sutures, limited to ages 14-18	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy, once per lifetime per permanent tooth; retreatment of previous root canal therapy, once per lifetime, not within 24 months when done by same dentist or dental office	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy and pulpal debridement; pulpal therapy and regeneration	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification (endodontists only), limited to ages 6-16; apicoectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, per root, per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Two periodontal cleanings following surgery per calendar year after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One (1) scaling and root planing per quadrant, per 24 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, once per quadrant, per 24 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per quadrant, per 24 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Guided tissue regeneration (natural teeth - resorbable and non-resorbable barriers, per site) and biologic materials to aid in osseous tissue regeneration	80%	None	Yes	60%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
2	Periodontic services, limited to:	Mesial/distal wedge procedure, single tooth	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Soft tissue allograft	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel, provisional, porcelain/ ceramic, all ceramic and resin-based composite crown for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one per 60 months from the original date of placement, per permanent tooth, per patient	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures twice per year, and five total per 5 years	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of dentures that cannot be repaired after 5 years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Addition of teeth or clasp to existing partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	One relining of existing removable dentures; or rebonding or recementing fixed denture; per 24 months (only after 6 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth); reline of custom sleep apnea appliance (indirect)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction and repair of bridges (replacement of a bridge that cannot be repaired), limited to once in 60 months	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Obturator prosthesis and modification, mandibular resection prosthesis or trismus appliance	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Fluoride and/or topical medication carrier for patients undergoing radiation treatment	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Tissue conditioning (not covered when performed within 6 months of any denture)	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion	50%	None	No	0%	N/A	N/A

Plan Exclusions

Please refer to the section in your Certificate of Coverage titled "State-Specific Exclusions" for additional exclusions, if applicable.

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services related to the treatment of TMD (Temporomandibular Disorder).
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth including third molars. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review.
12. Services not listed as covered.
13. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions except if the developmental malformation and/or congenital conditions cause severe, dysfunctional handicapping malocclusion that requires medically necessary orthodontia services.
15. Procedures, that in the opinion of the Plan, are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate (if not treatable through orthodontics), malignancies or neoplasms.
17. Orthodontics is only covered if medically necessary as determined by the Plan. The Invisalign system and similar specialized braces are not a covered benefit. Patient co-insurance will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.