



## 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<sup>2</sup>

Choice PPO network offers access to over 350,000 dentists nationally.<sup>1,3</sup>

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.<sup>3,4</sup>

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.



#### MEMBER PORTAL

[DominionMembers.com](https://DominionMembers.com)



#### GO MOBILE COMMUNICATION SERVICE

Register at [DominionNational.com/go](https://DominionNational.com/go) or by calling 888.596.0716



#### LIVE CHAT SUPPORT

Visit [DominionNational.com](https://DominionNational.com) to chat with a live agent.



**TOLL-FREE, 24 HOUR ACCESS at 888.518.5338**

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

### VALUE-ADDED BENEFITS

#### HEARING DISCOUNT PROGRAM

[amplifonusa.com/dn](https://amplifonusa.com/dn)

Access to discounts on hearing aids and services.<sup>5</sup>

#### DIGIBITE TELEDENTISTRY APP

[DominionNational.com/teledentistry](https://DominionNational.com/teledentistry)

Receive a dental consultation without leaving your home or office!

#### Z DENTAL DISCOUNT

[Myzsonic.com/DN](https://Myzsonic.com/DN)

Access exclusive discounts on premium oral care products and accessories offered by Z Dental.

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](https://amplifonusa.com/dn) for full details. Hearing services are administered by Amplifon Hearing Health Care Corp.

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



**Choice PPO Basic Kids (FL)  
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 <sup>1</sup> | Waiting Period |
| 1   | Diagnostic & Preventive Services | 100%                | None           | 80%                    | None           |
| 2   | Basic Services                   | 35%                 | None           | 20%                    | None           |
| 3   | Major Services                   | 25%                 | None           | 10%                    | None           |
| 4   | Orthodontic Services             | 50%                 | None           | 30%                    | None           |
| <b>Annual Deductible</b>  |                                  | <b>In-Network</b>   |                | <b>Out-of-Network</b>  |                |
| Single Child  |                                  | \$100               |                | \$100                  |                |
| Two or More Children  |                                  | \$200               |                | \$200                  |                |
| Applies To  |                                  | Class 2 and Class 3 |                | Class 2 and Class 3    |                |
| <ul style="list-style-type: none"> <li>Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member’s dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is \$200 per Calendar Year at which point the deductible is waived for remaining pediatric members.</li> <li>The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.</li> </ul>                     |                                  |                     |                |                        |                |
| <b>Out-of-Pocket Maximum for In-Network Covered Services</b>  |                                  |                     |                |                        |                |
| Single Child  |                                  | \$400               |                |                        |                |
| Two or More Children  |                                  | \$800               |                |                        |                |
| <ul style="list-style-type: none"> <li>The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.</li> <li>There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.</li> <li>The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.</li> </ul>  |                                  |                     |                |                        |                |
| <b>Out-of-Network Allowance</b>   |                                  | <b>In-Network</b>   |                | <b>Out-of-Network</b>  |                |
|   |                                  | N/A                 |                | MAC                    |                |
| <p>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.</p> |                                  |                     |                |                        |                |

- If course of treatment is to exceed \$300, pre-authorization is required.

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

| 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 per six (6) months  | 100%       | None                    | No                       | 80%            | None                    | No                       |
| 1             | Limited oral evaluation - problem focused or emergency oral evaluation                   | One per six (6) months  | 100%       | None                    | No                       | 80%            | None                    | No                       |
| 1             | Prophylaxis/cleaning   | One per six (6) months  | 100%       | None                    | No                       | 80%            | None                    | No                       |
| 1             | Fluoride treatment, topical application  | Two per twelve (12) months  | 100%       | None                    | No                       | 80%            | None                    | No                       |
| 1             | Bitewing x-rays  | Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one set per six (6) months   | 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 60 months   | 100%       | None                    | No                       | 80%            | None                    | No                       |
| 1             | Space maintainer   | Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer  | 100%       | None                    | No                       | 80%            | None                    | No                       |
| 1             | Sealants or preventive resin restoration   | One per tooth per 36 months (limited to occlusal surfaces of permanent molar 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   | Composite resin restorations limited to anterior teeth only; coverage for resins on posterior teeth is limited to the corresponding amalgam benefit   | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 2             | Pin retention of fillings  | Per tooth, only in conjunction with a permanent amalgam or composite filling restoration  | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 2             | Crown build-up for non-vital teeth and cast and prefabricated post and core              | Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure  | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 2             | Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown | Once per tooth, per 60 months; prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration | 35%        | None                    | Yes                      | 20%            | 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             | Emergency palliative treatment or after-hours office visit   | Only if no services other than exam and x-rays were performed on the same date of service  | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 2             | General anesthesia and analgesic, including intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide | Must be administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant   | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 2             | Recent cast or prefabricated post and core, inlay or onlay, crown, bridge  |  | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 2             | Therapeutic parenteral drug administration   |  | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 2             | Diagnostic casts   |  | 35%        | None                    | Yes                      | 20%            | None                    | Yes                      |
| 3             | Oral surgery, including postoperative care for:  | Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of pericoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; excision of hyperplastic tissue, vestibuloplasty | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Oral surgery, including postoperative care for:  | Tooth re-implantation and/or stabilization; tooth transplantation  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Oral surgery, including postoperative care for:  | Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Oral surgery, including postoperative care for:  | Buccal/labial and lingual frenectomy   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:  | Root canal therapy and retreatment of previous root canal therapy  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:  | Pulp caps, direct and indirect (includes sedative filling); pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation; hemisection, including any root removal  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:  | Pulpal therapy limited to primary teeth only   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:  | Treatment of root canal obstruction, no surgical access  | 25%        | None                    | Yes                      | 10%            | 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? |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: | Incomplete endodontic therapy, inoperable or fractured tooth   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: | Internal root repair of perforation defects  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: | Apexification/recalcification for permanent and primary teeth; apicoectomy/periradicular surgery               | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: | Retrograde fillings  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Four periodontal maintenance or prophylaxis following surgery per 12 months                                    | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Scaling and root planing, once per 24 months per quadrant  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue    | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Gingivectomy or gingivoplasty, once per 36 months per quadrant   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Gingival flap procedure, including scaling and root planing, per quadrant once per 36 months                   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Osseous surgery including flap entry and closure and scaling and root planing, once per 36 months per quadrant | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Clinical crown lengthening - hard tissue   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | One pedicle, free soft tissue, subepithelial connective tissue   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Subepithelial connective tissue graft procedure  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Full mouth debridement, once per lifetime  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Bone replacement graft, once per 36 months when tooth is present   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Distal or proximal wedge procedure, not in conjunction with osseous surgery, once per 36 months                | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Surgical revision procedure, per tooth, once per 36 months   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Periodontic services, limited to:   | Guided tissue regeneration, once per 36 months when tooth is present   | 25%        | None                    | Yes                      | 10%            | 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? |
| 3             | Restoration services, limited to: | Cast metal, resin-based or porcelain/ceramic inlay, onlay, and crown for permanent tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Restoration services, limited to: | Labial veneers   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Restoration services, limited to: | Crown, inlay, onlay and veneer repair  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Prosthetic services, limited to:  | Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to partial denture   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Prosthetic services, limited to:  | Simple stress breakers, per unit   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Prosthetic services, limited to:  | Rebase or reline full or partial denture limited to once per 36 months; denture rebases or relines done within 6 months are considered to be part of the denture placement when the rebase or reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 months after the insertion of the denture.   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Prosthetic services, limited to:  | Recementing or repairing fixed partial denture, by report  | 25%        | None                    | Yes                      | 10%            | 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  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Prosthetic services, limited to:  | Tissue conditioning  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Implants and related services     | Dental implants and related services including implant supported crowns and retainer for fixed partial denture, abutment supported crown and retainer for fixed partial denture, bridges, complete dentures, and/or partial dentures; implant/abutment supported removable denture for completely or partially edentulous arch, implant/abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 months | 25%        | None                    | Yes                      | 10%            | 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? |
| 3             | Implants and related services                                    | Surgical placement of implant body, endosteal implant; surgical placement of eposteal or transosteal implant  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Implants and related services                                    | Radiographs/surgical implant index, limited to once per arch per 60 months  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Implants and related services                                    | Repair implant supported prosthesis, abutment and implant removal   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Occlusal guards  | Limited to one per 12 months  | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 3             | Infiltration of sustained release therapeutic drug, per quadrant |   | 25%        | None                    | Yes                      | 10%            | None                    | Yes                      |
| 4             | <b>*MEDICALLY NECESSARY*</b><br>Orthodontia Services:            | Diagnostic, active and retention treatment to include removable fixed appliance therapy, limited, interceptive or comprehensive therapy; Orthodontia services are only provided for severe, dysfunctional, handicapping malocclusion with prior authorization | 50%        | None                    | No                       | 30%            | None                    | No                       |

### Plan Exclusions

The plan excludes and will not reimburse for the following services or charges:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. 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. 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 or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.