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.

MEMBER PORTAL
DominionMembers.com

GO MOBILE COMMUNICATION SERVICE
Register at DominionNational.com/go or by calling 888.596.0716

LIVE CHAT SUPPORT
Visit 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

SmileDirectClub
DominionNational.com/sdc
Orthodontic clear aligners offer a cost-effective alternative to traditional braces.[5]

HEARING DISCOUNT PROGRAM
amplifonusa.com/dn
Access to discounts on hearing aids and services.[6]

DIGIBITE TELEDENTISTRY APP
DominionNational.com/teledentistry
Receive a dental consultation without leaving your home or office!

Z DENTAL DISCOUNT
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 DominionNational.com/sdc for full details. Not all individuals are suitable candidates for clear aligners. These services, which are offered and arranged for by SmileDirectClub, are intended for certain individuals who have mild or moderate orthodontic needs and only if approved by a state-licensed dentist or orthodontist. Dominion National is not a provider of dental care services.
6 Visit 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").

DOMINION® NATIONAL DENTAL

Choice PPO Premium *Kids* (MI) 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	0%	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 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 $100 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

Out-of-Pocket Maximum for In-Network Covered Services	
Single Child	$400
Two or More Children	$800

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- 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.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

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, 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, examinations or limited problem focused re-evaluations	Limited to two (2) per Calendar Year	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation		100%	None	No	80%	None	No
1	Comprehensive oral evaluation		100%	None	No	80%	None	No
1	Prophylaxis/cleaning	Limited to three (3) per Calendar Year	100%	None	No	80%	None	No
1	Fluoride treatment, topical application		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 Calendar Year	100%	None	No	80%	None	No
1	Intraoral periapical or occlusal images	Not on the same date of service as a panoramic radiograph	100%	None	No	80%	None	No
1	Full mouth, complete series or panoramic radiograph	Limited to 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; removal of fixed space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restorations	Limited to 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		80%	None	Yes	60%	None	Yes
2	Pin retention of fillings		80%	None	Yes	60%	None	Yes
2	Protective restoration		80%	None	Yes	60%	None	Yes
2	Consultations	Diagnostic service provided by dentist or physician other than requesting dentist or physician	80%	None	Yes	60%	None	Yes
2	Crown build-up for non-vital teeth		80%	None	Yes	60%	None	Yes
2	Cast and prefabricated post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and peridontally	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 stainless steel crown, prefabricated resin crown and resin composite crown		80%	None	Yes	60%	None	Yes
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	80%	None	Yes	60%	None	Yes
2	General anesthesia and analgesic, including intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide		80%	None	Yes	60%	None	Yes
2	Recement cast or prefabricated post and core, inlay, onlay, crown		80%	None	Yes	60%	None	Yes
2	Pulp vitality tests		80%	None	Yes	60%	None	Yes
2	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Accession of tissue, gross and microscopic examination, preparation and transmission of written report		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; surgical access of an erupted tooth; excision of hyperplastic tissue; biopsy of soft tissue; brush biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy, frenulectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; and retreatment of previous root canal therapy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy limited to primary teeth only	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	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	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Incomplete endodontic therapy, inoperable or fractured tooth	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Hemisection, including any root removal	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Periodontal maintenance	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening, hard tissue	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Apically positioned flap	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, resin-based, porcelain/ceramic, titanium inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Labial veneer	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown and bridge repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of fixed bridges including bridge abutments and pontics; each abutment and pontic makes up a unit in a bridge	50%	None	Yes	30%	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 existing partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline complete or partial denture	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture	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?
3	Prosthetic services, limited to:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes
4	Orthodontia Services:	Not Covered	0%	None	No	0%	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. Orthodontia services are not covered.