



## 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 Premium Kids (NC)  
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	80%	None	60%	None
3	Major Services	50%	None	30%	None
4	Orthodontic Services	50%	None	30%	None
<b>Annual Deductible</b>		<b>In-Network</b>		<b>Out-of-Network</b>	
Single Child		\$50		\$50	
Two or More Children		\$100		\$100	
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 \$100 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 evaluation (D0120, D0145, D0150, D0160 or D0180) per six (6) months	100%	None	No	80%	None	No
1	Limited evaluation or re-evaluation, problem focused (D0140 or D0170)	One per six (6) 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	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	Application of caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer (D1510, D1516 or D1517) 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	One per tooth per 36 months (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	Restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations; protective restorations 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 for non-vital teeth	Once per tooth, per 60 months	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 peridontally, limited to one per tooth per 60 months	80%	None	Yes	60%	None	Yes
2	Prefabricated porcelain and stainless steel crown	Once per tooth, per 60 months; stainless steel crown under age 15	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	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 non-intravenous sedation	Maximum of 60 minutes of services allowed (general anesthesia is not covered with procedure codes D9230, D9239 or D9243; intravenous conscious sedation is not covered with procedure codes D9222, D9223 or D9230; non-intravenous conscious sedation is not covered with procedure codes D9222, D9223 or D9230; analgesia (nitrous oxide) is not covered with procedure codes D9222, D9223, D9239 or D9243); requires a narrative of medical necessity be maintained in patient records	80%	None	Yes	60%	None	Yes
2	Recent 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	Diagnostic casts		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty; excision of pericoronal gingiva; removal of exostosis; 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:	Coronectomy, intentional partial tooth removal, one (1) per lifetime, impacted teeth only	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:	Suture of recent small wounds up to 5 cm	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Bone replacement graft for ridge preservation-per site	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy	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	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps; pulpotomy and pulpal debridement; root amputation per root	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy (D3230 and D3240) limited to once per tooth per lifetime	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:	Pulpal regeneration limited to once per tooth per lifetime	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:	Pulpal regeneration (D3355, D3356 and D3357) limited to once per tooth per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Surgical exposure of root and surgical repair of root resorption	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Four periodontal cleanings following surgery per calendar year after definitive periodontal therapy	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:	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110/ D1120, limited to once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingival flap procedure, including root planing - 1-3 or 4+ contiguous teeth or tooth-bounded spaces, per quadrant once per 36 months	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 36 months per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Clinical crown lengthening	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 per 36 months	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, one per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Bone replacement graft, once per quadrant, per 36 months	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:	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
2	Periodontic services, limited to:	Soft tissue allograft, once per quadrant, per 36 months	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth 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	Restoration services, limited to:	Resin infiltration/smooth surface, limited to one in 36 months	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Crown, inlay, onlay and veneer repair	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Initial placement of 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:	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:	One relining of existing removable dentures; or rebonding or recementing fixed denture; per 36 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:	Rebase or reline complete or partial denture limited to once per 36 months (only after 6 months from date of initial installation)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture, by report	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:	Tissue conditioning	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Cleaning and inspection of removable dentures, once every 6 months	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	Implants and related services (only if determined to be medically necessary)	Dental implants and related services including implant supported crowns, abutments, bridges, complete dentures, and/or partial dentures. Limited to 1 every 60 months	50%	None	Yes	30%	None	Yes
3	Scaling and debridement in the presence of inflammation or mucositis of a single implant	One (1) per two (2) years, including cleaning of the implant surfaces, without flap entry and closure	50%	None	Yes	30%	None	Yes
3	Occlusal guards	Occlusal guard (hard appliance or soft appliance, full arch; hard appliance, partial arch) limited to 1 in 12 months for patients 13 and older; occlusal guard adjustments limited to 1 every 24 months	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		50%	None	Yes	30%	None	Yes
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	30%	None	No

### Plan Exclusions

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

1. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
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 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. Treatment required for conditions resulting from acts of terrorism are not excluded.
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) beyond the extent that an otherwise covered dental service is provided.\*
18. Treatment of malignancies or neoplasms.
19. Orthodontics is only covered if medically necessary.

\* The plan will cover congenital defects and anomalies, including cleft palate, to the same extent an otherwise covered dental service is provided by the plan.