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 OVER 900,000 MEMBERS,[1] 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.[3,5]

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

MyDOMINION MOBILE APP
Download at DominionNational.com/mobile

A COMMITMENT TO MEMBER SATISFACTION

In a recent Member Satisfaction Survey, 99% of the respondents were satisfied with Dominion as their dental plan.[4]

TOLL-FREE, 24 HOUR ACCESS at 888.518.5338

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

VALUE-ADDED BENEFITS

SmileDirectClub[6]
DominionNational.com/sdc
Orthodontic clear aligners offer a cost-effective alternative to traditional braces.

HEARING DISCOUNT PROGRAM
amplifonusa.com/dn
Access to significant savings on hearing aids and services.[7]

1 Dominion National Internal Performance Report, 2020.
2 Networks vary by state. Check availability on your state marketplace.
3 Participating providers are subject to change.
4 Dominion National Member Satisfaction Survey, October 2020.
5 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, 2020. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.
6 Cost of traditional braces based on average total fees for treatment of mild-to-moderate malocclusion. Data on file at SmileDirectClub. 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. For complete details, visit DominionNational.com/sdc.
7 Based on Amplifon Hearing Health Care average member savings data for 2020. Pricing valid only at participating in-network locations. Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services and its own financial and contractual obligations. Hearing services are administered by Amplifon Hearing Health Care, Corp. Dominion National is not a provider of, nor provides coverage for, hearing health care services. For complete details, visit amplifonusa.com/dn.

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

DOMINION® NATIONAL DENTAL

Elite PPO Premium *Kids* (PA) Coverage Schedule, Limitations and Exclusions for Pediatric Services (under age 19)

- under age 19 (coverage continues through end of month 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	$375	N/A
Two or More Children	$750	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, 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 (1) evaluation (D0120, D0140, D0150 or D0180) per six (6) months, per patient; D0160 is covered.	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One (1) per six (6) months, per patient	100%	None	No	80%	None	No
1	Fluoride treatment	One (1) per six (6) months, per patient	100%	None	No	80%	None	No
1	Bitewing x-rays	One (1) 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 (1) per 60 months; maximum of one (1) set of x-rays per office visit	100%	None	No	80%	None	No
1	Interim caries arresting medicament	One application per primary tooth is covered per lifetime	100%	None	No	80%	None	No
1	Space maintainer (D1516, D1517, D1526 or D1527)	To preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); D1575 limited to one (1) per 24 months	100%	None	No	80%	None	No
1	Sealants	One (1) 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	80%	None	Yes	60%	None	Yes
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one (1) pin	80%	None	Yes	60%	None	Yes
2	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service	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	General anesthesia and analgesic	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, including intravenous and non-intravenous sedation with a 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 code D9222, D9223 or D9230; non-intravenous conscious sedation 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	Analysis and limited/ complete adjustment, one (1) in 12 months for patients 13 and older, by report	80%	None	Yes	60%	None	Yes
2	Prefabricated stainless steel or porcelain crown	One (1) per 60 months from the original date of placement, per permanent tooth, per patient for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	80%	None	Yes	60%	None	Yes
2	Addition of teeth to existing partial denture		80%	None	Yes	60%	None	Yes
2	Relining or rebasing of existing removable dentures	One (1) per 36 months; only after six (6) months from date of last placement, unless an immediate prosthesis replacing at least three (3) teeth	80%	None	Yes	60%	None	Yes
2	Repair of crowns, dentures and bridges		80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Extraction of tooth root	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Coronectomy, intentional partial tooth removal, one per lifetime	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Alveolectomy, alveoplasty, and frenectomy	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:	Excision of periocoronal gingiva, exostosis or hyper plastic tissue, and excision of oral tissue for biopsy	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:	Excision of a tumor or cyst and incision and drainage of an abscess or cyst	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; 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:	Pulpotomy; apicoectomy	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings, one (1) per root per lifetime	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Two (2) periodontal cleanings, in addition to adult prophylaxis, per calendar year, within 24 months after definitive periodontal therapy	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Root scaling and planing, one (1) per 24 months, per quadrant, per patient	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 one (1) per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy, one (1) per 36 months per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, one (1) per 36 months per patient, per quadrant	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle or free soft tissue graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement, one (1) per lifetime	80%	None	Yes	60%	None	Yes
3	Study model	One (1) per 36 months	50%	None	Yes	30%	None	Yes
3	Restoration services, limited to:	Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite onlay, or crown for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; one (1) per 60 months from the original date of placement, per permanent tooth, per patient	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	Restoration services, limited to:	Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally; protective restoration; post removal; crown buildup for non-vital teeth	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:	Replacement of dentures that cannot be repaired after five (5) years from the date of last placement	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Construction of bridges, replacement limited to one (1) per 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	Replacement of implant crowns limited to one (1) in 60 months	50%	None	Yes	30%	None	Yes
3	Implants and related services	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.	50%	None	Yes	30%	None	Yes
3	Infiltration of sustained release therapeutic drug - single or multiple sites		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	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.
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 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.