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.**

98% MEMBER SATISFACTION RATE[4]

TOLL-FREE, 24 HOUR ACCESS at 888.518.5338

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

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

VALUE-ADDED BENEFITS

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

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

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

1 Dominion National Internal Performance Report, 2021.
2 Networks and products vary by state. Check availability on your state marketplace.
3 Participating providers are subject to change.
4 Dominion National customer satisfaction survey, based on renewing members, 2021.
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, 2021. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.
6 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.
7 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

Elite PPO Premium *Kids* (VA) 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 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 maxmium 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 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.
- The single child out-of-pocket maxmium amount must be met by one child prior to satisfying the two or more children out-of-pocket maxmium 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	One (D0120, D0145 or D0150) per six (6) months, per patient	100%	None	No	80%	None	No
1	Re-evaluation, limited or problem focused	One exam per six (6) months, per patient	100%	None	No	80%	None	No
1	Prophylaxis (D1110 or D1120)	One per six (6) months, per patient	100%	None	No	80%	None	No
1	Fluoride treatments	One per six (6) months, per patient	100%	None	No	80%	None	No
1	Bitewing x-rays		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 x-rays		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 maintainers	One per 24 months, per quadrant (unilateral) or per arch (bilateral), per patient 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); D1575 limited to once per 24 months	100%	None	No	80%	None	No
1	Sealants	One per tooth, per lifetime (limited to occlusal surfaces of posterior permanent teeth without restorations or decay)	100%	None	No	80%	None	No
1	Diagnostic cast	Only if not in conjunction with orthodontic treatment	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; per tooth, per surface every 12 months	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	Local anesthesia; general anesthesia and analgesic, including intravenous and non-intravenous sedation	Maximum of 150 minutes or 10 units of general anesthesia and sedation allowed; requires a narrative of medical necessity be maintained in patient records. The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment	80%	None	Yes	60%	None	Yes
2	Hospital call	Facility and anesthesia charges are considered medical services; services delivered to the patient on the date of service are documented separately using applicable procedure codes; requires coordination and approval from both the dental insurer and the medical insurer before services can be rendered	80%	None	Yes	60%	None	Yes
2	Occlusal guard	For grinding and clenching of teeth, by report	80%	None	Yes	60%	None	Yes
2	Therapeutic parenteral drug administration	Note medication on claim; desensitizing medicaments	80%	None	Yes	60%	None	Yes
2	Consultations	When not performed by another dentist within the same facility and not in conjunction with orthodontia	80%	None	Yes	60%	None	Yes
2	Prefabricated crowns	Once per tooth, per 36 months	80%	None	Yes	60%	None	Yes
2	Temporary crowns	Coverage only for a fractured tooth	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
2	Recement cast or prefabricated post and core; recement crown		80%	None	Yes	60%	None	Yes
2	Protective restoration		80%	None	Yes	60%	None	Yes
2	Labial veneer	One (1) per 60 months, per tooth (will be considered as an alternative to a full restoration for an endodontically treated tooth)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root or partial tooth	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:	Coronectomy, intentional partial tooth removal, one (1) per lifetime	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	One (1) alveoloplasty per quadrant per patient per lifetime; one (1) frenulectomy or frenuloplasty per patient per lifetime	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	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 benign lesion, tumor or cyst and incision and drainage of an abscess or cyst	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Removal of oral tissue, odontogenic cyst, torus palatinus and mandibularis (D7285, D7286)	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Oroantral fistula closure and primary closure of a sinus perforation	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Biopsy	80%	None	Yes	60%	None	Yes
2	Oral surgery, including postoperative care for:	Occlusal orthotic device for TMJ (D7880)	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 permanent tooth, per lifetime, per patient; retreatment of previous root canal therapy, once per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpotomy and pulp cap; pulpal therapy and pulpal debridement; pulpal regeneration	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification limited to one (1) per tooth per provider, per lifetime; D3352 limited to three (3) treatments per tooth, per provider, per lifetime	80%	None	Yes	60%	None	Yes
2	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Periradicular surgery without apicoectomy, one 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:	Apicoectomy, one (1) per tooth, per patient, per lifetime	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:	Four periodontal cleanings following surgery per 12 months after definitive periodontal therapy	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:	One (1) scaling and root planing, 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 D1120/ D1110, limited to once per two years	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Occlusal adjustment performed with covered surgery	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Gingivectomy or gingivoplasty, once per 24 months, per quadrant, per patient	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Osseous surgery including flap entry and closure, once per 60 months, per quadrant, per patient	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Provisional splinting	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Pedicle, subepithelial, bone replacement or free soft tissue graft	80%	None	Yes	60%	None	Yes
2	Periodontic services, limited to:	Full mouth debridement, one (1) per 12 months, only covered when there is substantial gingival inflammation in all four (4) quadrants	80%	None	Yes	60%	None	Yes
3	Restoration services, limited to:	Cast metal crown, porcelain/ ceramic crown, porcelain/ ceramic onlay, all ceramic crown and resin-based composite onlay (D2644), only 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 complete or partial dentures	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Immediate denture, one per arch per lifetime per patient	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Repair of dentures; rebonding or recementing fixed denture; denture adjustment	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Replacement of complete or partial 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:	Addition of teeth or clasp to existing 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:	One (1) relining or rebasing of existing removable dentures per tooth per 24 months (only after six (6) months from date of last placement)	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Feeding aid (D5951)	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:	Recement fixed partials as needed	50%	None	Yes	30%	None	Yes
3	Prosthetic services, limited to:	Pontics and retainers, one per 60 months per patient per tooth	50%	None	Yes	30%	None	Yes
4	*MEDICALLY NECESSARY* Orthodontia Services:	Diagnostic, active and retention treatment to include removable and fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting), replacement of lost or broken retainer (D8692), and comprehensive therapy; Orthodontia services limited to once per lifetime and are only provided for severe, dysfunctional, handicapping malocclusion.	50%	None	No	0%	None	No

Plan Exclusions

Please refer to the section in your Individual Dental Policy titled "State-Specific Exclusions or Exceptions" for additional exclusions and/or exceptions to the following exclusions, if applicable.

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 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) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires medically necessary orthodontia services or an occlusal orthotic device, by report, for temporomandibular pain, dysfunction or associated musculature.
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, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. 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.
16. Treatment of cleft palate (if not treatable through orthodontics), malignancies or neoplasms.
17. Orthodontics is only covered if medically necessary. 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, including pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, one set of retainers and 12 months of retainer adjustments. Additional costs incurred will become the patient's responsibility.