2026

Teethkeepers

A program brought to you
by Dominion National

Dental & Vision Benefits for Everyone

DOMINION®
NATIONAL

DOMINION NATIONAL IS A
LEADING
INSURER AND
ADMINISTRATOR OF

DENTAL + VISION
BENEFITS

WE PROUDLY SERVE

- HEALTH PLANS
- EMPLOYER GROUPS
- MUNICIPALITIES
- ASSOCIATIONS
- INDIVIDUALS

PLANS AS *unique* AS YOU

Dominion National understands that every individual is unique, which is why we've designed plans and programs that work for you. Our goal is to offer flexible options and exceptional service, so you can focus on what makes you thrive.

The Teethkeepers program is open to everyone and provides dental and vision benefits directly to individuals who are self-employed, do not have access to these benefits through an employer, or are simply looking for additional coverage. Choose the plan that best fits your lifestyle and needs.

A VARIETY OF DENTAL OPTIONS AVAILABLE

PPO PLAN HIGHLIGHTS[1]

AVAILABLE IN DC, DE, FL, GA, IL, IN, MD, MI, MO, NC, NJ, OH, OR, PA, VA AND WI

- Flexibility to use any dentist
- Lower out-of-pocket cost when using a network dentist
- Plans ranging from $1,000 to $1,500 annual maximum limit (no limit on PPO Preventive)
- No waiting periods on PPO Preventive, Basic and Plus options

SELECT PLAN HIGHLIGHTS

AVAILABLE IN DC, DE, MD, PA, VA AND PARTS OF NJ[2]

- Must use a participating dentist
- Predictable, fixed fees for dental procedures
- No waiting periods or deductibles
- No annual maximum limit on services
- Orthodontic coverage for both children and adults
- Discounts on implant services
- Extra cleanings for diabetics and expecting mothers available at a copayment

ELITE EPPO PLAN HIGHLIGHTS

AVAILABLE IN DC, MD, PA AND VA

- Must use a participating dentist
- Predictable, fixed fees for dental procedures
- No waiting periods
- Annual rollover benefits
- Implant coverage

PREVENTION REWARDS PROGRAM

Get Cleanings. Get Rewarded!
The primary subscriber will receive a $20 reward from Dominion for themselves and each enrolled family member who gets two cleanings in a calendar year from a participating dentist.

1 PPO Basic is not available in Ohio. Plan names and benefits may vary. See plan documents on Teethkeepers.com for full detials.
2 Managed care plan with exclusive network, fixed member copayments, no annual maximum dollar limits, no waiting periods and no deductibles. In New Jersey, the Select Plan is available in Camden, Cumberland and Gloucester counties only.

Enclosed you will find a sample listing of exclusions and limitations relating to the product type; however, the complete list of exclusions and limitations may differ depending on the specific plan you choose. For the complete list of exclusions and limitations that apply to a specific plan, please obtain the plan document online at Teethkeepers.com.

ADULT PLAN HIGHLIGHTS COMPARISON

	PPO Preventive	PPO Basic	PPO Plus	PPO Premium	Select Plan Basic	Select Plan Premium	Elite ePPO
Must use a participating dentist					•	•	•
Prevention Rewards	•	•	•	•	•	•	•
Waiting periods				•			
No charge for routine semiannual cleanings (in-network)	•	•	•	•		•	•
Additional cleaning covered for diabetics and expecting mothers					•	•	
Orthodontics					•	•	
Implant service discounts or coverage					•	•	•
Fixed fees for dental procedures					•	•	•
Office visit charge	N/A	N/A	N/A	N/A	$10	$10	N/A
Annual maximum	No limit	$1,000	$1,000	$1,500	No limit	No limit	$1,500
Annual rollover benefits							•
Deductibles per adult (x3 adult max)	$50[1]	$50[1]	$50[1]	$50[2]	None	None	$25[2]
Pediatric pairing	PPO Basic *Kids*	PPO Basic *Kids*	PPO Basic *Kids*	PPO Premium *Kids*	Select Plan Basic *Kids*	Select Plan Premium *Kids*	PPO Basic *Kids*

DOMINION NATIONAL MEMBERS HAVE ACCESS TO A ROBUST DENTAL NETWORK.

In fact, 90% of Dominion members have access to two dentists within 10 miles of their homes.[3]

Effective January 1, 2014, most Americans must obtain pediatric dental coverage for dependents under the age of 19 that complies with the EHB provisions under the Patient Protection and Affordable Care Act (PPACA). If you do not have this coverage through your health insurance plan, you may enroll your dependent(s) in Dominion's pediatric dental plan to ensure that you are meeting the requirements of PPACA. Individuals under the age of 19 who enroll in a Select Plan, Elite ePPO or PPO plan (as a subscriber or a dependent) will automatically be enrolled in the pediatric dental plan. For full coverage details regarding Dominion's certified pediatric dental plans, please visit DominionNational.com/pediatric.

1 Deductibles apply to all services.
2 Deductibles apply to basic care and major restorative care.
3 Dominion National Network Analysis Report, 2023. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia. Participating dentists are subject to change.

PLAN COMPARISON - *ADULTS* (AGE 19 & OVER)

	PPO Preventive[1]		PPO Basic[1,8]						PPO Plus[1]		PPO Premium[1]		Select Plan Basic[7]	Select Plan Premium[7]	Elite ePPO Basic[7]
Procedures and Covered Services	In-Network	Out-of-Network	In-Network			Out-of-Network			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	In-Network
			Year 1[3]	Year 2[3]	Year 3[3]	Year 1[3]	Year 2[3]	Year 3[3]							
Diagnostic and Preventive Care	100%	80%	100%	100%	100%	90%	90%	90%	100%	90%	100%	90%	90-100%	100%	100%
Oral Exams	100%	80%	100%	100%	100%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%
Bitewing X-Rays	100%	80%	100%	100%	100%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%
Teeth cleanings (two per year)	100%	80%	100%	100%	100%	90%	90%	90%	100%	90%	100%	90%	90%	100%	100%
Basic Care	0%	0%	50%	60%	80%	30%	50%	70%	50%	40%	80%	70%	70-85%	75-85%	80-90%
Full and panoramic X-rays	100% (Class I)	80% (Class I)	50%	60%	80%	30%	50%	70%	100% (Class I)	90% (Class I)	100% (Class I)	90% (Class I)	85%	85%	100% (Class I)
Amalgam fillings (silver)	0%	0%	50%	60%	80%	30%	50%	70%	50%	40%	80%	70%	80%	85%	90%
Composite fillings (white)	0%	0%	50%	60%	80%	30%	50%	70%	50%	40%	80%	70%	75%	75%	90%
Extraction, erupted tooth	0%	0%	50%	60%	80%	30%	50%	70%	50%	40%	80%	70%	70%	75%	80%
Major Restorative Care[4]	0%	0%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%	60-70%	60-70%	50-80%
Prosthetics															
Crowns	0%	0%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%	60%	60%	60%
Bridges	0%	0%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%	65%	65%	60%
Dentures	0%	0%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%	70%	70%	75%
Relining of dentures	0%	0%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%	65%	70%	80%
Periodontics	0%	0%	15%	25%	50%	10%	20%	40%	50% (Class II)	40% (Class II)	50%	40%	70%	70%	70%
Endodontics	0%	0%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%	70%	70%	50%
Oral Surgery	0%	0%	15%	25%	50%	10%	20%	40%	0%	0%	50%	40%	70%	70%	70%
Orthodontics	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	40%	40%	0%
Benefit Features															
Office Visit	None		None						None		None		$10	$10	None
Deductibles	$50 per adult (adult max $150)[2]		$50 per adult (adult max $150)[2]						$50 per adult (adult max $150)[2]		$50 per adult (adult max $150)[5]		None	None	$25 per adult (adult max $75)[5]
Annual Maximums	No limit		$1,000 per insured person						$1,000 per insured person		$1,500 per insured person		No limit	No limit	$1,500 per insured person
Waiting Periods	None		None						None		Yes[6]		None	None	None
Receive Care From	Elite PPO Network Dentist (DC, DE, MD, PA, VA), Choice PPO Network Dentist (FL, GA, IL, IN, MI, MO, NC, NJ, OH, OR, WI) or any licensed dentist												Select Plan Network Dentist		Elite ePPO Network Dentist

In the event of ambiguity, or conflict between this summary and the plan document, the plan document shall control.

1 In GA, out-of-network coinsurances will be the same as the in-network coinsurances. When using an out-of-network provider, members may incur any charges exceeding the allowed amount.
2 Deductibles apply to all services.
3 Year 1 benefits apply during the subscriber's first 12 months of continuous coverage. Year 2 benefits apply during the subscriber's second 12 months of continuous coverage. Year 3 benefits apply during the subscriber's third 12 months of continuous coverage.
4 In NJ, Year 1 Major Restorative Care coinsurance is 30% in-network and 25% out-of-network. Year 2 Major Restorative Care coinsurance is 40% in-network and 30% out-of-network.
5 Deductibles apply to basic care and major restorative care.
6 There are no waiting periods for diagnostic and preventive care. To be eligible for basic care, you must have completed 6 (six) months of continuous coverage. To be eligible for major restorative care, you must have completed 12 (twelve) months of continuous coverage. Waiting period credit will be given for the length of time an insured was covered under each benefit classification under the current employer's prior dental coverage.
7 Based on the Context4Healthcare's 80th percentile for zip 220. Coverage for ortho is based on Dominion's 80th percentile of in-network and out-of-network claims data for D8080 and D8090 from 2016 to 2019. Specific fee schedules apply to adult and pediatric plans and can be viewed at Teethkeepers.com and DominionNational.com/pediatric.
8 PPO Basic is not available in Ohio.

MONTHLY RATES - EFFECTIVE 1/1/26-12/1/26

Rates are valid through December 2026. You will receive a notice if there is a change to the plan rates or covered benefits prior to January 2027.

PPO PER ADULT (Age)	1	2	3	4	5	6	7	8	9[1]	10[1]	11[1]	12[1]	13[1]	14[1]	15[1]	16[1]	17[1]	18[1]	19[1]
PPO Preventive (19-29)	$13.70	$12.48	$13.30	$13.21	$8.56	$7.30	$9.49	$9.49	$11.80	$12.23	$15.79	$10.30	$10.55	$9.59	$8.04	$8.96	$8.94	$8.51	$11.14
PPO Preventive (30-45)	$15.39	$14.02	$14.93	$14.83	$9.61	$8.19	$10.65	$10.65	$13.25	$13.73	$17.72	$11.56	$10.55	$10.77	$9.02	$10.06	$10.03	$9.55	$12.51
PPO Preventive (46+)	$17.17	$15.64	$16.66	$16.55	$10.73	$9.15	$11.89	$11.89	$14.79	$15.33	$19.78	$12.90	$10.55	$12.02	$10.07	$11.23	$11.20	$10.66	$13.96
PPO Basic (19-29)	$22.52	$26.31	$19.59	$17.73	$18.49	$15.75	$19.58	$19.58	$24.41	$21.53	$29.30	$21.40	$22.32	$19.94	$17.23	$18.50	$18.08	-	$22.62
PPO Basic (30-45)	$25.29	$29.54	$21.99	$19.91	$20.76	$17.68	$21.99	$21.99	$27.40	$24.18	$32.90	$24.02	$22.32	$22.38	$19.35	$20.77		-	$25.39
PPO Basic (46+)	$28.22	$32.97	$24.55	$22.22	$23.17	$19.74	$24.54	$24.54	$30.58	$26.98	$36.71	$26.81	$22.32	$24.98	$21.59	$23.19	$22.65	-	$28.34
PPO Plus (19-29)	$18.80	$19.87	$16.67	$15.20	$13.19	$11.23	$13.76	$13.76	$18.85	$18.55	$22.66	$17.20	$14.36	$16.86	$11.04	$12.53	$13.34	$15.38	$14.83
PPO Plus (30-45)	$21.10	$22.30	$18.72	$17.06	$14.81	$12.61	$15.45	$15.45	$21.17	$20.82	$25.45	$19.31	$14.36	$18.93	$12.39	$14.06	$14.98	$17.27	$16.65
PPO Plus (46+)	$23.55	$24.89	$20.89	$19.04	$16.53	$14.08	$17.25	$17.25	$23.62	$23.24	$28.40	$21.55	$14.36	$21.13	$13.83	$15.70	$16.72	$19.28	$18.59
PPO Premium (19-29)	$35.30	$36.86	$32.85	$29.63	$29.90	$25.48	$33.30	$33.30	$38.96	$32.77	$41.14	$36.89	$41.59	$40.48	$35.68	$37.94	$31.55	$40.08	$36.33
PPO Premium (30-45)	$39.63	$41.38	$36.88	$33.26	$33.57	$28.60	$37.39	$37.39	$43.74	$36.79	$46.19	$41.42	$41.59	$45.45	$40.06	$42.59	$35.43	$45.00	$40.79
PPO Premium (46+)	$44.23	$46.19	$41.16	$37.12	$37.47	$31.92	$41.73	$41.73	$48.82	$41.06	$51.55	$46.23	$41.59	$50.73	$44.71	$47.54	$39.54	$50.22	$45.52
PPO PER CHILD (Under Age 19) (Max Charge of 3 per family)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9[1]**	**10[1]**	**11[1]**	**12[1]**	**13[1]**	**14[1]**	**15[1]**	**16[1]**	**17[1]**	**18[1]**	**19[1]**
PPO Basic Kids	$26.64	$25.15	$27.43	$24.38	$22.43	$19.10	$27.25	$27.25	$27.36	$30.68	$27.10	$31.11	$31.53	$32.01	$28.05	$30.10	$24.57	$31.08	$29.08
PPO Premium Kids	$36.83	$33.15	$33.54	$30.49	$28.77	$24.51	$35.13	$35.13	$33.22	$37.66	$35.91	$48.44	$56.24	$56.96	$50.46	$47.32	$44.53	$56.90	$51.03
SELECT PLAN PER ADULT (Age)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
Select Plan Basic (19-29)	$14.40	$26.07	$9.34	$7.29	$7.50	$5.25	$14.38	$13.52	$12.25	-	-	-	–	–	–	–	–	–	–
Select Plan Basic (30-45)	$16.17	$29.27	$10.49	$8.19	$8.42	$5.90	$16.14	$15.17	$13.75	-	-	-	–	–	–	–	–	–	–
Select Plan Basic (46+)	$18.04	$32.67	$11.70	$9.14	$9.39	$6.58	$18.02	$16.94	$15.34	-	-	-	–	–	–	–	–	–	–
Select Plan Premium (19-29)	$18.13	$36.61	$11.84	$9.43	$10.41	$7.44	$18.28	$17.27	$15.75	-	-	-	–	–	–	–	–	–	–
Select Plan Premium (30-45)	$20.36	$41.10	$13.30	$10.58	$11.69	$8.36	$20.53	$19.39	$17.69	-	-	-	–	–	–	–	–	–	–
Select Plan Premium (46+)	$22.72	$45.87	$14.84	$11.81	$13.05	$9.33	$22.91	$21.64	$19.74	-	-	-	–	–	–	–	–	–	–
SELECT PLAN PER CHILD (Under Age 19) (Max Charge of 3 per family)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
Select Plan Basic Kids	$15.45	$19.53	$9.44	$8.04	$8.03	$6.58	$17.45	$16.95	$15.20	-	-	-	–	–	–	–	–	–	–
Select Plan Premium Kids	$21.95	$29.88	$12.96	$11.55	$11.99	$10.46	$22.45	$21.95	$20.38	-	-	-	–	–	–	–	–	–	–
Elite ePPO PER ADULT (Age)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
Elite ePPO Basic (19-29)	$28.53	-	$27.68	$25.02	$19.79	$16.85	$24.74	$24.74	-	-	-	-	–	–	–	–	–	–	–
Elite ePPO Basic (30-45)	$32.03	-	$31.08	$28.09	$22.21	$18.92	$27.78	$27.78	-	-	-	-	–	–	–	–	–	–	–
Elite ePPO Basic (46+)	$35.75	-	$34.69	$31.35	$24.79	$21.11	$31.00	$31.00	-	-	-	-	–	–	–	–	–	–	–
Elite ePPO PER CHILD (Under Age 19) (Max Charge of 3 per family)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
PPO Basic Kids	$26.64	-	$27.43	$24.38	$22.43	$19.10	$27.25	$27.25	-	-	-	-	–	–	–	–	–	–	–

1 PPO plans in regions 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19 are only available on the Choice PPO network

How to Calculate Your Monthly Rates

1. Determine your rating region based on your county or state of residence. See Region Legend on page 8.
2. Locate your monthly premium in the chart by referencing the rating region, your plan choice and your age band (range). This is your monthly rate if you are the only subscriber.
3. For each dependent, repeat step 2. You will only be charged for up to three child dependents.
4. Add up each family member's rate to determine your total monthly premium.

Example: A family of four living in Virginia, with two adults in the 30-45 age band and two children under age 19 enrolling in the PPO Basic plan:

1. Richmond City is in Region 8.
2. PPO Basic monthly rate in Region 8 in the 30-45 age band = $19.04.
3. Primary Subscriber (Adult 1) and Adult Dependent (Adult 2) = (2 x $19.04 = $38.08) + Dependent Child 1 and Dependent Child 2 = (2 x $22.52 = $45.04).
4. $38.08 + $45.04 = $83.12.

RATING REGIONS

Region Legend	
Region 1	DC
Region 2	DE
Region 3	MD counties: Montgomery, Prince George's
Region 4	MD counties: Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico[1], Worcester[1]
Region 5	PA counties: Adams[2,3], Berks, Bucks, Centre, Chester, Columbia[1], Cumberland, Dauphin, Delaware, Franklin[2,3], Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Schuylkill, Snyder, Union, York[2,3]
Region 6	PA counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Clarion, Clearfield, Clinton, Crawford, Elk, Erie, Fayette, Forrest, Greene, Huntingdon, Indiana, Jefferson, Lackawanna[1], Lawrence, Luzerne[1], Lycoming, McKean, Mercer, Monroe, Pike[1], Potter, Somerset, Sullivan, Susquehanna[1], Tioga, Venango, Warren, Washington, Wayne[1], Westmoreland, Wyoming
Region 7	VA counties: Alexandria City, Arlington, Clarke, Fairfax, Fairfax City, Falls Church City, Fauquier, Fredericksburg City, Loudoun, Manassas City, Manassas Park City, Prince William, Spotsylvania, Stafford, Warren
Region 8	VA counties: Albemarle[1], Alleghany, Amelia, Amherst, Appomattox, Augusta, Bath, Bedford[1], Bland[1], Botetourt, Brunswick, Buckingham, Buena Vista City, Campbell[1], Caroline, Carroll[1], Charles City, Charlotte, Charlottesville City[1], Chesapeake City, Chesterfield, Colonial Heights City, Covington City, Craig, Culpeper, Cumberland, Danville City[1], Dinwiddie, Emporia City, Essex, Floyd[1], Fluvanna, Franklin[1], Franklin City, Frederick[1], Galax City[1], Giles[1], Gloucester, Goochland, Greene, Greensville, Halifax, Hampton City, Hanover, Harrisonburg City[1], Henrico, Henry[1], Highland, Hopewell City, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lexington City, Louisa, Lunenburg, Lynchburg City, Madison, Martinsville City[1], Mathews, Mecklenburg, Middlesex, Montgomery[1], Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Nottoway, Orange, Page, Patrick[1], Petersburg City, Pittsylvania[1], Poquoson City, Portsmouth City, Powhatan, Prince Edward, Prince George, Pulaski[1], Radford City[1], Rappahannock, Richmond, Richmond City, Roanoke[1], Roanoke City[1], Rockbridge, Rockingham[1], Salem City[1], Shenandoah, Southampton, Staunton City, Suffolk City, Surry, Sussex, Virginia Beach City, Waynesboro City, Westmoreland, Williamsburg City, Winchester City, Wythe[1], York
Region 9[3]	NJ counties: Atlantic[1], Bergen[1], Burlington[1], Camden, Cape May[1], Cumberland, Essex[1], Gloucester, Hudson[1], Hunterdon[1], Mercer[1], Middlesex[1], Monmouth[1], Morris[1], Ocean[1], Passaic[1], Salem[1], Somerset[1], Sussex[1], Union[1], Warren[1]
Region 10	GA: All counties[1,3]
Region 11	OR: All counties[1,3]
Region 12	NC: All counties[1,3]
Region 13	FL: All counties[1,3]
Region 14	IL: All counties[1,3]
Region 15	IN: All counties[1,3]
Region 16	MI: All counties[1,3]
Region 17	MO: All counties (excluding Clark & Scotland)[1,3]
Region 18	OH: All counties[1,3]
Region 19	WI: All counties[1,3]

1 Select Plan is not available.
2 PPO is not available.
3 ePPO is not available.

ENROLL IN THE VISION PLAN

VISION PLAN 6030 HIGHLIGHTS

AVAILABLE IN DC, DE, GA, MD, NJ, OR, PA AND VA

$10 copay on annual in-network eye exams and lenses

You may use any licensed vision provider or choose from over 107,000 participating providers nationwide including Pearle Vision, Sears Optical, J.C. Penney, For Eyes Optical, Hour Eyes and Target Optical, along with independent optometrists, ophthalmologists and opticians[1]

No annual charge in-network for eyeglass frames up to $120 or contact lenses up to $100

15% discount off LASIK standard prices; 5% discount off promotional pricing

Smart Buyer Program: A helpful guide for purchasing eyewear:

- Use Vision Benefit Maximizer® to find a provider by location and frame inventory at $0 out-of-pocket cost
- Find out which frames looks best by face shape, hair color, skin tone and more!

Vision Plan 6030 At A Glance

Benefit Summary	Copay	Frequency
Exam	$10	12 Months
Lenses	$10	12 Months
Frames	None	12 Months
Contact Lenses (instead of glasses)	None	12 Months

Lenses Benefit Options (in-network) (in addition to lenses copayment above)	
UV Coating	$12
Tint	$10
Scratch Resistance	$10
Polycarbonate	$25
Anti-Reflective	$40
Standard Progressive	$50
Other Add Ons	Retail Discount

Maximum Allowances: Preferred Provider	
Frame	$120
Contact Lenses (instead of glasses)	$100

Maximum Allowances: Non-Preferred Provider	
Exam	$32
Frames	$60
Single Vision Lenses	$24
Bifocal Lenses	$36
Trifocal Lenses	$46
Contact Lenses	$75

Monthly Premium	
Subscriber	$8.99
Subscriber + 1	$15.57
Subscriber + 2 or More	$22.54

1 Dominion National Network Analysis Report, 2024
Participating providers are subject to change. All other brand names, product names or trademarks belongs to their respective holders.

Please note that vision benefits are not pediatric vision essential health benefits offered by a stand-alone vision plan under the Affordable Care Act.

Enclosed you will find a sample listing of exclusions and limitations relating to the product type; however, the complete list of exclusions and limitations may differ depending on the specific plan you choose. For the complete list of exclusions and limitations that apply to a specific plan, please obtain the plan document online at Teethkeepers.com.

DISCOUNT DENTAL PROGRAM[1]

DISCOUNT PROGRAM HIGHLIGHTS

AVAILABLE IN DC, MD, PA, VA AND PARTS OF NJ[2]

- Must use a participating dentist
- Predictable, fixed fees for dental procedures
- No waiting periods or deductibles
- No annual maximum limit on services
- Orthodontic discounts for both children and adults
- Discounts on implant services
- Extra cleanings for diabetics and expecting mothers available at a fee

Discount Program Features	
Must use a participating dentist	•
Waiting periods	None
No charge for routine annual cleanings	•
Additional cleaning covered for diabetics and expecting mothers	•
Orthodontics (adults and children)	•
Implant service discounts	•
Fixed fees for dental procedures	•
Office visit charge	$15
Annual maximum	No limit
Annual rollover benefits	N/A
Deductibles per adult (x3 adult max)	None
Pediatric pairing	N/A

Discount Program Monthly Rates	
Subscriber	$7.50
Subscriber + 1 or More	$10.00

Procedures and Discounted Services[3]	
Diagnostic and Preventive Care	65-100%
Oral Exams	100%
Bitewing X-Rays	65%
Teeth cleanings (one per year)	100%
Basic Care	60-70%
Full and panoramic X-rays	65%
Amalgam filings (silver)	70%
Composite filings (white)	60%
Extraction, erupted tooth	65%
Major Restorative Care	45-65%
Prosthetics	
Crowns	45%
Bridges	55%
Dentures	60%
Relining of dentures	55%
Periodontics	60%
Endodontics	65%
Oral Surgery	60%
Orthodontics (adults/children)	40-45%

1 This is not an insurance plan. It is a reduced fee-for-service program designed specifically for individuals. Members pay a predetermined reduced fee for listed services provided by contracted providers. Dominion does not pay providers for services provided by contracted providers. The Discount Program provides discounted fees for children; however, it does not include an EHB compliant pediatric plan.

2 In New Jersey, the Discount Program is available in Camden, Cumberland and Gloucester counties only.

3 Discount Program not available in Delaware.

4 Based on the Context4Healthcare's 80th percentile for zip 220. Discounts for ortho is based on Dominion 's 80th percentile of in-network and out-of-network claims data for D8080 and D8090 from 2016-2019. A specific fee schedule applies and can be viewed at Teethkeepers.com.

DOMINION® NATIONAL

VALUE-ADDED MEMBER BENEFITS

As a Dominion National member, you have access to additional benefits to help support you on your health and wellness journey.

PREVENTION REWARDS PROGRAM

Get Cleanings. Get Rewarded!

Primary subscribers will receive a $20 reward from Dominion for themselves and each enrolled family member who gets two cleanings in a calendar year from a participating dentist.

No extra steps are needed! Just visit your dentist twice a year for a cleaning, have them submit the claim and Dominion will automatically send you the reward check.

MEMBER SAVINGS ON ORAL CARE PRODUCTS WITH Z DENTAL

Access exclusive discounts on premium oral care products and accessories offered by Z Dental. Members can purchase the following types of Z Dental products:

- Z Sonic Water Flosser
- Z Sonic Pulse Toothbrush
- Z Sonic Featherweight Toothbrush
- Z Sonic Mini Toothbrush

To learn more and view products, visit MyZSonic.com/DN.

DISCOUNT HEARING PROGRAM THROUGH AMPLIFON HEARING HEALTH CARE

Dominion has partnered with global hearing care leader Amplifon to bring you a hearing discount program that offers savings averaging 64% off the retail price on more than 1,400 hearing aid options.[1] Visit amplifonusa.com/dn or call 855.565.1072 to connect with a hearing care advocate today.

1. 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 theadministration of hearing health care services and its own financial and contractual obligations. Dominion Dental Services, Inc., which operates under the trade name "Dominion National," and Amplifon are independent, unaffiliated companies. Dominion National is not a provider of, nor provides coverage for, hearing health care services. The Amplifon Hearing Health Care discount program is not approved for use with any 3rd party payor program, including government and private third-party payor programs. Hearing services are administered by Amplifon Hearing Health Care, Corp. Notice of this Amplifon offering is for informational purposes only and is not medical advice.

WHO IS ELIGIBLE FOR THE DENTAL & VISION PLAN?

You and your dependents are eligible. Dependents include your spouse and unmarried children up to age 26, regardless of student status. Dependents are covered through the end of the plan year in which they turn 26, unless otherwise stated in your plan document.

HOW DO I JOIN THE DENTAL & VISION PLAN?

There are two ways for you to enroll.

1. ONLINE: Go to Teethkeepers.com, which contains detailed plan comparisons and FAQs to assist you. Select your state and county to view the plans available to you. This will also allow you to begin the online enrollment process.
2. BY MAIL: You may also fill out the hard copy Enrollment Card by selecting a dental and/or vision plan or the discount program and/or vision plan. Be sure to list all dependents you want covered.Additional dependents can be listed on the back of the Enrollment Card, if necessary.
   - Select Plan Only: Please select a dentist and fill in the "Dental Office Name & Code #" box in the Enrollment Card. You can find a list of participating Select Plan dentists at DominionNational.com/teethkeepersdentists. - Please note that, on the website, the Code # is listed as "Facility #". You may select a dentist later. however, you must select a dentist prior to receiving care.
   - Sign and date the appropriate section of the Enrollment Card.
   - To pay by debit to your checking account or credit card, please fill out the Payment Authorization Card.
   - When you choose the monthly payment option, future monthly installments will be debited directly from your account. You will not receive monthly bills. Please attach a voided check to the Payment Authorization Card.
   - Return the completed Enrollment Card, Payment Authorization Card (if applicable) or payment (if applicable) to:

     Dominion National
     P.O. Box 75314
     Charlotte, NC 28275-5314

WHAT HAPPENS AFTER I ENROLL?

When you enroll, a Membership ID card and detailed coverage information will be sent to you. Once you are a member, you can create online account where you can find a dentist and view ID cards and plan information.

Member Portal: DominionMembers.com
Go Mobile Communication Service: Register by calling 888.596.0716
MyDominion Mobile Website: Visit DominionNational.com/mobile on your phone

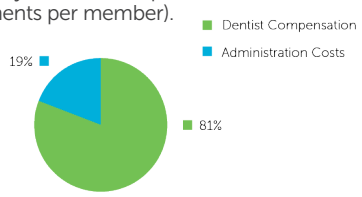
MARYLAND PREMIUM DISTRIBUTION CHART

The following explanation as required by the Maryland Insurance Administration.

Dental

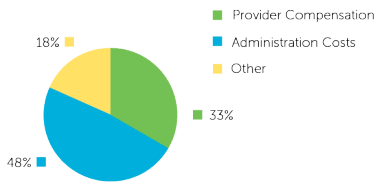
Dominion is licensed as a Dental Plan Organization (DPO) in the State of Maryland. PPO dentists are paid through the traditional discounted fee-for-service model. Select Plan network dentists are paid through a combination of member copayments and capitation dollars (predetermined monthly payments per member).

This chart shows how premium dollars were distributed in 2024 between dentist compensation and administration costs.



Vision

This chart shows how premium dollars were distributed in 2024 between provider compensation and administration costs.



DOMINION®
NATIONAL

With a strict commitment to quality care, adherence to the highest ethical standards and constant attention to administrative responsiveness, speed and accuracy...

WE WORK FOR YOUR Benefit®

P.O. Box 21522
Eagan, MN 55121-0522
888.518.5338

DOMINION® NATIONAL

IMPORTANT NOTICE:

This is a sample listing of exclusions and limitations relating to the product type; however, the complete list of exclusions and limitations may differ depending on the specific plan you choose. For the complete list of exclusions and limitations that apply to a specific plan, please obtain the plan document online at Teethkeepers.com.

Select Plan, Discount Program[1], PPO and ePPO Exclusions

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 as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Participating Dentist, 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. Procedures not listed as covered benefits under this Plan.
11. Services related to the treatment of TMD (Temporomandibular Disorder).
12. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth, including third molars.

Select Plan and Discount Program[1] Exclusions

1. Services which are not necessary for the patient's dental health as determined by the Plan.
2. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth, including third molars, as determined by the Plan.
3. Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating General Dentist. Above copayments do not apply when performed by a participating plan specialist (with the exception of orthodontics and palliative emergency pain treatment). Participating plan specialists, if available, have entered into an agreement with Dominion National to provide dental services to members at a 25% reduction from their Usual, Customary, and Reasonable (UCR) fees. This means that Member will be responsible for 25% of the lesser of a Participating Specialists UCR fee or the amount the provider has agreed to accept. Members must directly contact the Participating Specialist to obtain fees as the amount varies by provider.
4. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
5. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or Dominion National (with the exception of out-of-area emergency dental services).

PPO and ePPO Exclusions

1. Diagnosis or treatment of temporomandibular joint (TMJ) syndromes, problems and/or occlusal disharmony.
2. Treatment of cleft palate, malignancies or neoplasms.
3. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 12 months (PPO) or 36 months (ePPO) of Member's continuous coverage under the program.
4. 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.
5. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.

PPO Exclusions

1. Implants and related services; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.

Select Plan and Discount Program[1] Limitations

1. Two (2) evaluations are covered per calendar year including a maximum of one (1) comprehensive evaluation.
2. One (1) problem focused exam is covered per calendar year.
3. Select Plan - two (2) teeth cleanings (prophylaxis) are covered per calendar year. Discount Program - one (1) teeth cleaning (prophylaxis) is covered per calendar year.
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) bitewing x-rays are covered per calendar year.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
7. Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
8. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
9. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
10. Relining and rebasing of dentures is covered once every 24 months.
11. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
12. Root planing or scaling is covered once every 24 months per quadrant.
13. Full mouth debridement is covered once per lifetime.
14. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater.
15. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
16. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.
17. Select Plan – orthodontia treatment is limited to once per lifetime.

Select Plan and PPO Limitations

1. Coronectomy - intentional partial tooth removal, once per lifetime
2. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years
3. 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 once per two years
4. Teledentistry, synchronous (D9995) or asynchronous (D9996), must be accompanied by a covered procedure.

PPO and ePPO Limitations

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.

1. Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per Calendar Year
3. Two prophylaxis (cleaning, scaling and polishing teeth) per Calendar Year
4. Bitewing x-rays, 2 per Calendar Year

1 This is not an insurance plan. It is a reduced fee-for-service program designed specifically for individuals. Members pay a predetermined reduced fee for listed services provided by contracted providers. Dominion does not pay contracted providers for services.

IMPORTANT NOTICE:

This is a sample listing of exclusions and limitations relating to the product type; however, the complete list of exclusions and limitations may differ depending on the specific plan you choose. For the complete list of exclusions and limitations that apply to a specific plan, please obtain the plan document online at Teethkeepers.com.

5. Periapical x-rays
6. One diagnostic x-ray, full or panoramic per 60 months
7. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
8. Simple extraction of teeth
9. Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), excluding pre-molar and molar composite fillings, per tooth, per surface every 24 months
10. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
11. Antibiotic injections administered by a dentist
12. Oral surgery, including postoperative care for: a. Removal of teeth, including impacted teeth; b. Extraction of tooth root; c. Alveolectomy, alveoplasty,and frenectomy; d. Excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy; e. Tooth reimplantation and/or stabilization; f. Tooth transplantation; and g. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
13. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage); b. Pulpotomy; c. Apicoectomy and d. Retrograde fillings, one per root per lifetime
14. Periodontic services, limited to: a. Two periodontal maintenance following surgery per Calendar Year; b. One scaling and root planing per quadrant per 24 months from age 21; c. Occlusal adjustment performed with covered surgery; d. Gingivectomy; e. Osseous surgery including flap entry and closure; f. One pedicle or free soft tissue graft per site per lifetime; g. One occlusal guard (night guards) per 5 years within 6 months of osseous surgery; and h. One full mouth debridement per lifetime
15. One study model per 36 months
16. Crown build-up for non-vital teeth
17. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter
18. One repair of dentures or fixed bridgework per 24 months
19. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery
20. Restoration services, limited to: a. Cast metal, resin-based, gold or porcelain/ceramic inlay, onlay, and crown limited to a tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced; c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally
21. Prosthetic services, limited to: a. Initial placement of dentures or fixed bridgework; b. Replacement of removable dentures or fixed bridges that cannot be repaired after 7 years from the date of last placement; c. Addition of teeth to existing partial denture; and d. One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth
22. Orthodontia for adults is not covered.

Vision Plan Exclusions

1. 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.
2. Services which are covered under Medicare, worker's compensation, employer's liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law (Pennsylvania policyholders only).
3. Services and treatment provided without charge or for which there would be no charge in the absence of insurance. DOES NOT APPLY TO MEDICAID.
4. Services not listed as covered.
5. Hospitalization for any vision procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Orthoptic or vision training and any associated supplemental testing.
8. Plano lenses.
9. Two pair of glasses, in lieu of bifocals or trifocals.
10. Medical or surgical treatment of the eyes.
11. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
12. Customization of bifocal lenses to a progressive or no-line lens.
13. Photo-chromatic lenses.
14. Sub-normal vision aids or non-prescription lenses.
15. Services rendered or materials purchased outside the U.S. or Canada, unless: a) the Member resides in the U.S. or Canada; and b) the charges are incurred while on a business or pleasure trip.
16. Charges in excess of the usual and customary charge for the service or materials.
17. Charges incurred after: a) the Policy ends; or b) the Member's coverage under the Policy ends, except as stated in the Policy. Maryland policyholders only: Also subject to the Extension of Benefits provision.
18. Experimental or non-conventional treatment or device as determined by treating provider.
19. Spectacle lens treatments or "add-ons," except solid tints (#1 & #2), and oversize lenses.
20. High Index lenses of any material type.
21. Lost or broken materials, except when replaced at normal intervals when services are available.
22. Maryland policyholders only: Any bill, or demand for payment, for a vision service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

Vision Plan Limitations

Plan will pay for eligible expenses (subject to benefit coverage) incurred by or on behalf of Subscriber and/or their Dependents while covered under the Policy including:

A. Services: Include, but are not limited to:

1. Vision Examinations - Each Subscriber and eligible Dependent(s) is entitled to a complete analysis of the eyes and related structures to determine vision problems and other abnormalities. Plan will cover such service once every 12 months. Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such materials will be covered, together with certain services as necessary.
2. Prescribing and ordering proper lenses.
3. Assisting with selection of frames.
4. Verifying accuracy of finished lenses.
5. Proper fitting and adjustments.

B. Materials:

1. Lenses: Plan will pay for lenses on a new prescription for standard lenses once every 12 months. The lens allowance equals two (2) lenses. If only one (1) lens is needed the allowance will be half (1/2) the lens allowance.
2. Frames: Plan will pay for frames once every 12 months.
3. Contact Lenses: Plan will pay for contact lenses once every 12 months.

Plan Limitations: In no event will payment exceed the lesser of:

1. The actual cost of covered services or materials; or
2. The limits of the Policy, shown in this schedule.

NOTICE OF NONDISCRIMINATION

Discrimination is against the law. The Dominion National group of companies (including insurer Dominion Dental Services, Inc. and administrator Dominion Dental Services USA, Inc.) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Dominion National does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Dominion National provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 888.518.5338 (TTY: 711).

If you believe that Dominion National has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance by mail, fax, or email at:

Dominion National
PO Box 21522 Eagan, MN 55121-0522
888.518.5338 (TTY: 711), fax: 703.518.4450
CRC@DominionNational.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

We provide language assistance services and auxiliary aids free of charge by calling 888.518.5338 (TTY: 711).

Ofrecemos servicios de asistencia lingüística y ayuda auxiliar sin costo llamando al 888.518.5338 (TTY: 711).

请致电 888.518.5338 (TTY: 711)获取我们免费提供的语言协助服务和辅助工具。

我們免費提供語言協助服務與輔助工具，若有需要請致電 888.518.5338 (TTY:711).

Мы бесплатно предоставляем услуги языковой поддержки и вспомогательные средства по телефону 888.518.5338 (TTY: 711).

Nagbibigay kami ng mga serbisyo ng tulong sa wika at mga dagdag na tulong nang walang bayad sa pamamagitan ng pagtawag sa 888.518.5338 (TTY: 711).

Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và các thiết bị hỗ trợ miễn phí thông qua số 888.518.5338 (TTY: 711).

نوفر خدمات المساعدة اللغوية والمساعدات الإضافية مجانًا عن طريق الاتصال بالرقم 888.518.5338 (TTY: 711).

888.518.5338 (TTY: 711)번으로 전화하시면 무료로 언어 지원 서비스와 보조 지원 서비스를 제공해 드립니다.

Prestamos serviços linguísticos e de assistência auxiliar gratuitos ligando para o número 888.518.5338 (TTY: 711).

Nous fournissons des services d’assistance linguistique et des aides auxiliaires à titre gratuit au 888.518.5338 (TTY : 711).

Nou bay sèvis asistans pou lang ak èd siplemantè gratis; pou jwenn èd rele nan 888.518.5338 (TTY: 711).

Forniamo gratuitamente servizi di assistenza linguistica e supporti ausiliari chiamando il numero 888.518.5338 (TTY: 711).

અમે 888.518.5338 (TTY: 711) પર કૉલ કરીને નિઃશુલ્ક ભાષા સહાય સેવાઓ અને સહાયક સહાય પ્રદાન કરીએ છીએ.

Zapewniamy bezpłatne usługi językowe i pomocnicze pod numerem telefonu 888.518.5338 (TTY: 711).

የቋንቋ እገዛ አገልግሎቶች እና የኦግዚላሪ እርዳታዎችን በ 888.518.5338 (TTY: 711) ላይ በመደወል ከክፍያ ነጻ እናቀርባለን።

भाषा सहायता सेवाएं और सहायक उपकरण निःशुल्क प्राप्त करने के लिए 888.518.5338 (TTY: 711) पर कॉल करें।

Dominion National Payment Authorization Card

Automatic Payment Plan

Choose one of our two convenient options below.

Pay By Credit Card Debit: ❑ **Automatic Monthly Debits**

Credit Card Number: _____ C.C. Verification Code: _____

Credit Card Type: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Name as it appears on card: _____

Expiration Date: _____

Pay By Checking Account Debit: ❑ **Automatic Monthly Debits**

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Terms and Authorization

Pay By Credit Card: By selecting the Automatic Monthly Debits option you authorize Dominion National or its authorized agent to automatically deduct future monthly premium payments from your credit card account.

Pay By Checking Account Debit: By selecting the Automatic Monthly Debits and submitting a voided check or a check for the first month's premium, you authorize Dominion National or its authorized agent to automatically deduct future monthly premium payments from your checking account.

TERMS: This authorization will remain in effect unless 30 days advance written notice of termination is received by Dominion National In the event that any electronic debit or transfer is returned, I agree that a $25.00 returned item fee will be automatically charged to my account.

AUTHORIZATION: In exchange for providing the dental and vision coverage selected in my enrollment form, I understand that Dominion, or its authorized agent, will automatically deduct the monthly premium amount on or after the 20th day of each month from the credit card or bank account listed above.[1] Automatic deductions will begin the month before the Effective Date. For example, if the Effective Date of coverage is 1/1/2026, the first automatic debit will be made on or after 12/20/2025. This authorization will remain in effect unless I give 30 days advance written notice of termination to Dominion. In the event that any electronic debit or transfer is returned, I agree that a $25.00 returned item fee will be automatically charged to my account for each return.

[1] Maryland subscribers will be debited on or after the 1st day of each month, beginning the month of the Effective Date. For example, if the Effective Date for a Maryland subscriber is 1/1/2026, the first automatic debit will be made on or after 1/1/2026.

Signature: _____ Date: _____

Agent/Broker Use Only

Agent/Broker # _____ General Agent # _____

District of Columbia Residents

Dominion Dental Services, Inc.
Arlington, VA

Avalon Insurance Company
Harrisburg, PA

Dental and Vision Enrollment Card

DENTAL
SELECT ONE:

- ☐ I choose the Dominion Discount Program[1]
- ☐ I choose the Dominion Select Plan Basic[2]
- ☐ I choose the Dominion Select Plan Premium[2]
- ☐ I choose the Dominion Elite ePPO[2]
- ☐ I choose the Dominion Elite PPO[2]
  - ☐ Elite PPO Preventive
  - ☐ Elite PPO Basic
  - ☐ Elite PPO Plus
  - ☐ Elite PPO Premium

VISION
SELECT ONE:

- ☐ I choose the Avalon vision[3] plan 6030

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address		Home Phone
City	State / ZIP	Work Phone
Email Address		Cell Phone*

* By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? Dental ☐ Yes ☐ No Vision ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Domestic Partner				
Child				
Child				
Child				
Child				
Child				

SELECT PLAN or DISCOUNT PROGRAM
Provider Selection

Dental Office Name & Code #
(As Indicated on Your Dentist Directory)

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion National, if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion National, P.O. Box 75314 Charlotte, NC 28275-5314

[1] This is a reduced fee-for-service program designed specifically for individuals. It is not an insurance product, regulated by the State Insurance Department, or covered by any state's guarantee fund or corporation.
[2] The dental plans are underwritten by Dominion Dental Services, Inc.
[3] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Dental Services USA, Inc.

District of Columbia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Delaware Residents

Dominion Dental Services, Inc.
Arlington, VA

Avalon Insurance Company
Harrisburg, PA

Dental and Vision Enrollment Card

DENTAL
SELECT ONE:

- ☐ I choose the Dominion Select Plan Basic[1]
- ☐ I choose the Dominion Select Plan Premium[1]
- ☐ I choose the Dominion Elite ePPO[1]
- ☐ I choose the Dominion Elite PPO[1]
  - ☐ Elite PPO Preventive
  - ☐ Elite PPO Basic
  - ☐ Elite PPO Plus
  - ☐ Elite PPO Premium

VISION
SELECT ONE:

- ☐ I choose the Avalon vision[2] plan 6030

Enrollment Information

Last Name	First Name		M.I.
Sex ☐ M ☐ F		Birthdate (MM/DD/YY)	
Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Cell Phone*

* By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? Dental ☐ Yes ☐ No Vision ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Domestic Partner				
Child				
Child				
Child				
Child				
Child				

SELECT PLAN or DISCOUNT PROGRAM
Provider Selection

Dental Office Name & Code #
(As Indicated on Your Dentist Directory)

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion National, if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion National, P.O. Box 75314 Charlotte, NC 28275-5314

[1] The dental plans are underwritten by Dominion Dental Services, Inc.
[2] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Dental Services USA, Inc.

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Florida Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE: ☐ I choose the Choice PPO
- ☐ Choice PPO Basic Plan
- ☐ Choice PPO Plus Plan
- ☐ Choice PPO Premium Plan
- ☐ Choice PPO Preventive Plan

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address		Home Phone
City	State / ZIP	Work Phone
Email Address		Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who knowingly or with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____ Date _____

Producer Name _____ Agent/Broker Number _____ Agent/Broker FL License ID Number _____

Georgia Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental/Vision Enrollment Card

SELECT ONE: ☐ I choose the Vision Plan

☐ I choose the Dental Choice PPO

- ☐ Choice PPO Basic Plan
- ☐ Choice PPO Plus Plan
- ☐ Choice PPO Premium Plan
- ☐ Choice PPO Preventive Plan

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address	Home Phone	
City / State / ZIP	Work Phone	
Email Address	Cell Phone*	

* By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion National, if enrolled in the dental plan or vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion National, P.O. Box 75314 Charlotte, NC 28275-5314

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE:

- ☐ I choose the Dental Choice PPO Basic Plan
- ☐ I choose the Dental Choice PPO Plus Plan
- ☐ I choose the Dental Choice PPO Premium Plan
- ☐ I choose the Dental Choice PPO Preventive Plan

Enrollment Information			
Last Name	First Name		M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)		
Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____

Producer Name _____ Agent/Broker Number_____ Date _____

Indiana Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE: ☐ I choose the Choice PPO
☐ Choice PPO Basic Plan
☐ Choice PPO Plus Plan
☐ Choice PPO Premium Plan
☐ Choice PPO Preventive Plan

Enrollment Information			
Last Name	First Name		M.I.
Sex ☐ M ☐ F		Birthdate (MM/DD/YY)	
Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____

Producer Name _____ Agent/Broker Number_____ Date _____

Maryland Residents

Dominion Dental Services, Inc.
Arlington, VA

Avalon Insurance Company
Harrisburg, PA

Dental and Vision Enrollment Card

DENTAL
SELECT ONE:

- ☐ I choose the Dominion Discount Program[1]
- ☐ I choose the Dominion Select Plan Basic[2]
- ☐ I choose the Dominion Select Plan Premium[2]
- ☐ I choose the Dominion Elite ePPO Basic[2]
- ☐ I choose the Dominion Elite PPO[2]
  - ☐ Elite PPO Preventive
  - ☐ Elite PPO Basic
  - ☐ Elite PPO Plus
  - ☐ Elite PPO Premium

VISION
SELECT ONE:

- ☐ I choose the Avalon vision[3] plan 6030

Enrollment Information

Last Name	First Name		M.I.
Sex ☐ M ☐ F		Birthdate (MM/DD/YY)	
Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Cell Phone*

* By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? Dental ☐ Yes ☐ No Vision ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Domestic Partner				
Child				
Child				
Child				
Child				
Child				

SELECT PLAN or DISCOUNT PROGRAM
Provider Selection

Dental Office Name & Code #
(As Indicated on Your Dentist Directory)

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion National, if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion National, P.O. Box 75314 Charlotte, NC 28275-5314

[1] This is a reduced fee-for-service program designed specifically for individuals. It is not an insurance product, regulated by the State Insurance Department, or covered by any state's guarantee fund or corporation.
[2] The dental plans are underwritten by Dominion Dental Services, Inc.
[3] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Dental Services USA, Inc.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Michigan Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE:

☐ I choose the Dental Choice PPO Basic Plan
☐ I choose the Dental Choice PPO Plus Plan
☐ I choose the Dental Choice PPO Premium Plan
☐ I choose the Dental Choice PPO Preventive Plan

Enrollment Information

Last Name	First Name		M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)		
Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____

Producer Name _____ Agent/Broker Number_____ Date _____

Missouri Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE: ☐ I choose the Choice PPO
☐ Choice PPO Basic Plan
☐ Choice PPO Plus Plan
☐ Choice PPO Premium Plan
☐ Choice PPO Preventive Plan

Enrollment Information			
Last Name	First Name		M.I.
Sex ☐ M ☐ F		Birthdate (MM/DD/YY)	
Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____

Producer Name _____ Agent/Broker Number_____ Date _____

DMN(MO)26D-IND

North Carolina Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE: ☐ I choose the Choice PPO
- ☐ Choice PPO Basic Plan
- ☐ Choice PPO Plus Plan
- ☐ Choice PPO Premium Plan
- ☐ Choice PPO Preventive Plan

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address		Home Phone
City	State / ZIP	Work Phone
Email Address		Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to [Dominion Dental Services, Inc.], if enrolled in the dental plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____

Producer Name _____ Agent/Broker Number_____ Date _____

DMN(NC)26D-IND

Ohio Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE: ☐ I choose the Choice PPO
☐ Choice PPO Basic Plan
☐ Choice PPO Premium Plan

Enrollment Information			
Last Name	First Name		M.I.
Sex ☐ M ☐ F		Birthdate (MM/DD/YY)	
Home Address			Home Phone
City	State	ZIP	Work Phone
Email Address			Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____

Producer Name _____ Agent/Broker Number_____ Date _____

Oregon Residents

Dominion National
Arlington, VA

Individual Dental/Vision Enrollment Card

SELECT ONE: ☐ I choose the Vision Plan
☐ I choose the Dental Choice PPO Plan
- ☐ Choice PPO Basic Plan
- ☐ Choice PPO Plus Plan
- ☐ Choice PPO Premium Plan
- ☐ Choice PPO Preventive Plan

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	

Home Address	Home Phone
City / State / ZIP	Work Phone
Email Address	Cell Phone*

* By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Domestic Partner				
Child				
Child				
Child				
Child				
Child				

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion National for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion National, P.O. Box 75314 Charlotte, NC 28275-5314

Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

The state of Oregon recognizes and authorizes domestic partnerships. An Oregon registered domestic partnership is defined as a civil contract entered into in person between two individuals who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.

The dental and vision plans are underwritten by Dominion Dental Services, Inc.

DN(OR)26DV-IND

Pennsylvania Residents

Dominion Dental Services, Inc.
Arlington, VA

Avalon Insurance Company
Harrisburg, PA

Dental and Vision Enrollment Card

DENTAL
SELECT ONE:

- ☐ I choose the Dominion Discount Program[1]
- ☐ I choose the Dominion Select Plan Basic[2]
- ☐ I choose the Dominion Select Plan Premium[2]
- ☐ I choose the Dominion Elite ePPO[2]
- ☐ I choose the Dominion Elite PPO[2]
  - ☐ Elite PPO Preventive
  - ☐ Elite PPO Basic
  - ☐ Elite PPO Plus
  - ☐ Elite PPO Premium

VISION
SELECT ONE:

- ☐ I choose the Avalon vision[3] plan 6030

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address		Home Phone
City	State / ZIP	Work Phone
Email Address		Cell Phone*

* By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? Dental ☐ Yes ☐ No Vision ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Domestic Partner				
Child				
Child				
Child				
Child				
Child				

SELECT PLAN or DISCOUNT PROGRAM
Provider Selection

Dental Office Name & Code #
(As Indicated on Your Dentist Directory)

I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion National, if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion National, P.O. Box 75314 Charlotte, NC 28275-5314

[1] This is a reduced fee-for-service program designed specifically for individuals. It is not an insurance product, regulated by the State Insurance Department, or covered by any state's guarantee fund or corporation.
[2] The dental plans are underwritten by Dominion Dental Services, Inc.
[3] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Dental Services USA, Inc.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dominion Dental Services, Inc.
251 18th Street South, Suite 900
Arlington, VA 22202

Virginia Residents

Avalon Insurance Company
2500 Elmerton Avenue
Harrisburg, PA 17177

Dental and Vision Enrollment Card

DENTAL
SELECT ONE:

- ☐ I choose the Dominion Select Plan Basic[1]
- ☐ I choose the Dominion Select Plan Premium[1]
- ☐ I choose the Dominion Elite ePPO[1]
- ☐ I choose the Dominion Elite PPO[1]
  - ☐ Elite PPO Preventive
  - ☐ Elite PPO Basic
  - ☐ Elite PPO Plus
  - ☐ Elite PPO Premium

VISION
SELECT ONE:

- ☐ I choose the Avalon vision[2] plan 6030

THESE ARE EXCEPTED BENEFITS POLICIES. THEY PROVIDE COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICIES.

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address	Home Phone	
City / State / ZIP	Work Phone	
Email Address	Cell Phone*	

* By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? Dental ☐ Yes ☐ No Vision ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse				
Child				
Child				
Child				
Child				
Child				

SELECT PLAN
Provider Selection

Dental Office Name & Code #
(As Indicated on Your Dentist Directory)

The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion National, if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to member or their authorized representative upon request.

The Elite PPO Basic plan includes waiting periods for basic and major services for members age 19 and over. All plans may have a reduction in benefits as the result of another insurer providing coverage for the same loss.

Signature _____ Date _____

Agent/Broker Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion National, P.O. Box 75314 Charlotte, NC 28275-5314

[1] The dental plan is underwritten by Dominion Dental Services, Inc. (hereinafter referred to as "Dominion National").
[2] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Dental Services USA, Inc.

Virginia - Any person who, with the intent to defraud or knowing that s/he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

ePPO means Exclusive Preferred Provider Organization and PPO means Preferred Prov Organization. The ePPO is an in-network only plan and the PPO plan offers both in- and out-of-network benefits.

DMN(VA-ONLY)26DVIND

Wisconsin Residents

Dominion Dental Services, Inc.
Arlington, VA

Individual Dental Enrollment Card

SELECT ONE: ☐ I choose the Choice PPO
- ☐ Choice PPO Basic Plan
- ☐ Choice PPO Plus Plan
- ☐ Choice PPO Premium Plan
- ☐ Choice PPO Preventive Plan

Enrollment Information

Last Name	First Name	M.I.
Sex ☐ M ☐ F	Birthdate (MM/DD/YY)	
Home Address		Home Phone
City	State / ZIP	Work Phone
Email Address		Cell Phone*

* By providing your cell phone number above, you authorize Dominion Dental Services, Inc. to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

Does this plan replace other coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse/Civil Union Partner/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

To the best of my knowledge and belief, all statements made in this enrollment form are true and complete. Additionally, I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature _____ Date _____

Agent/Broker #	Coverage Eff. Date

Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314

Producer Certification

☐ I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Producer Signature _____

Producer Name _____ Agent/Broker Number_____ Date _____

DMN(WI)26D-IND

NONGROUP ENROLLMENT/CHANGE REQUEST

Underwritten by: Dominion Dental Services, Inc.

A. Type of Activity – to be completed by Applicant/Member. *Refer to instructions on the last page before completing this form. Print clearly.*

ADD

☐ Enrollment of a new Applicant/Member
☐ Enrollment of the new Dependent(s)
☐ Enrollment of the Children(s) only
☐ Add Spouse/Civil Union Partner/Domestic Partner
☐ Add Domestic Partner to existing dental policy
☐ Add Family Member(s) to existing policy

Policyholder Name: _____
ID Number: _____

REMOVE

☐ Remove Insured Applicant/Member
☐ Remove Spouse/Civil Union Partner/Domestic Partner
☐ Remove Dependent Children(s)

Policyholder Name: _____
ID Number: _____

OTHER CHANGE

☐ Name Change Request
☐ Change Plan
☐ Other
☐ Reinstatement

Policyholder Name: _____
ID Number: _____

Select Requested Effective Date: _____

B. Applicant/Member Information	Name (Last, First, MI):

SSN:	Birthdate (mm/dd/yyyy)	☐ Male ☐ Female _____	Email Address:

Are you a resident of New Jersey? ☐ Yes ☐ No

Do you maintain a home in any other state or country? ☐ Yes ☐ No *If yes:*
Name of State/Country:_____ Number of months you live there each year: _____

Address Information

Primary Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Home Ph: (_____)_____ Cell Ph: (_____)_____

Other Residence:
Street/Apt:_____
Street/Apt:_____
City:_____ State:_____
Zip Code: _____
Home Ph: (_____)_____ Cell Ph: (_____)_____

Your billing address: ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:
Mailing address (for communications other than bills): ☐ Primary residence ☐ Other residence ☐ P.O. Box or Other *(specify)*:

By providing your cell phone number above, you authorize Dominion National to send Short Message Service (SMS) or text message communications directly to your cell phone. You may revoke your consent to receiving text communications at any time by replying "STOP" upon receipt of a message. Message and Data Rates May Apply.

C. Plan Option – *Select Plan(s) from the list below*

- ☐ I choose the Select Plan Basic Plan
- ☐ I choose the Select Plan Premium Plan
- ☐ I choose the Choice PPO Plan
  - ☐ Choice PPO Basic Plan
  - ☐ Choice PPO Premium Plan
  - ☐ Choice PPO Preventive Plan
  - ☐ Choice PPO Plus Plan
- ☐ I choose the Vision Plan
- ☐ I choose the Select Plan Basic *Pediatric* 702xs Plan
- ☐ I choose the Select Plan Premium *Pediatric* 706s Plan
- ☐ I choose the Choice PPO *Pediatric* Plan
  - ☐ Choice PPO Basic *Pediatric* Plan
  - ☐ Choice PPO Premium *Pediatric* Plan

Does this plan replace other coverage? ☐ Yes ☐ No

D. Other Individuals Covered – *Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you.*

1. Spouse/Domestic Partner/Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐ Other	☐ Add ☐ Remove ☐Other	☐ Add ☐ Remove ☐Other
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ __ MI:
Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):	Birthdate (mm/dd/yyyy):
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
If last name is different from [Applicant's], please explain: _____	If last name is different from Applicant's, please explain: _____ _____	If last name is different from Applicant's, please explain: _____ _____	If last name is different from [Applicant's], please explain: _____ _____
Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section [E]*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section [F]*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section [F]*	Home address same as Applicant? ☐ Yes ☐ No *If NO, complete Section [F]*

E. Additional Spouse/Domestic Partner/Civil Union Partner Information – *If not applicable, please mark as "NA."*

a. Street/Apt:_____ _____ City, State, Zip Code: _____	b. Please explain why the address is different: _____

F. Additional Child Information – *Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____ Street/Apt: _____ City, State, Zip Code:_____ Reason:	Name(s):_____ Street/Apt:_____ _____ City, State, Zip Code:_____ Reason:

G. Race/Ethnicity – R*esponse is appreciated but NOT required!*	*Choose a category that most closely describes you:* ☐American Indian or Alaskan Native ☐Black, not of Hispanic origin ☐Hispanic ☐Asian or Pacific Islander ☐White, not of Hispanic origin

H. Payment Information – *indicate how you would like to be billed and make payment*	☐ Monthly ☐ Check ☐Credit Card Type (AMEX, Visa, etc.):_____ Cardholder Name: ☐Debit Card Type (AMEX, Visa, etc.):_____ No.:_____ Exp. Date: ____/____/____ Cardholder Name: Information to visit website to authorize payment via credit and/or debit card.

To the best of my knowledge and belief, all statements made in this application are true and complete. Additionally, I understand and agree that my signature on this application serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of [dental and/or vision services]. Information will be released to [[Dominion National], if enrolled in the dental plan or vision plan,], for the purpose of investigation or evaluation of care in connection with a claim or complaint. Authorization will be limited to the term of coverage of this contract. A copy of the form will be made available to the Applicant/Member's Personal
Representative or their authorized representative upon request.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I. Applicant/Member Signature	I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form Signature: _____ Date: _____

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

Instructions

- ☆ You must complete sections A through I, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- ☆ Please PRINT except when a signature is requested.
- ☆ If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- ☆ If you are applying to add a spouse, civil union partner, domestic partner, or child please check the applicable box in the "Add" section in A **and** identity the applicable Triggering Event in the Reason section of the "Other Change" section in A.
- ☆ You can obtain the providers' correct names and addresses from the appropriate provider directory.
- ☆ For provider addresses, include the zip code plus the four digit extension (9 digits).
- ☆ IF YOU HAVE QUESTIONS concerning the benefits and services provide by or excluded under this policy, contact a member services representative at 888.518.5338 before signing this form.
- ☆ KEEP A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Dominion National. Coverage must be verified with Dominion National prior to visiting with a specialist or admission to a hospital.

Eligibility

A. You MUST be a New Jersey resident which means your primary residence is in New Jersey.
B. If application is made for the Catastrophic Plan, the following additional requirements apply:
   1. You must be under 30 years old; OR
   2. You must have a notice that you qualify for an exemption with an Exemption Certificate Number (ECN) from the Marketplace. Attach a copy of that notice to your application.

Mail this application to:
Dominion National
P.O Box 75314 Charlotte, NC 28275-5314

The **Annual Open Enrollment Period** begins November 1 and ends January 31 each year, and is the designated period of time during which you may apply for or change coverage for yourself and family members who are currently uninsured or who are covered under another individual plan, or who are covered under a group health plan, group health benefits plan, a governmental plan, a church plan. Your application must be signed, dated and mailed during the Annual Open Enrollment Period. If you apply for coverage by December 31, the effective date of coverage will be January 1 of the immediately following year. If you apply for coverage between January 1 and January 31, the effective date of coverage will be February 1 of the same year.

A **Special Enrollment Period** that lasts for 60 days follows the listed Triggering Events. The effective date of a new policy will be no later than the first [or fifteenth] of the month following receipt of the application. In addition, if the Triggering Event is the loss of eligibility for minimum essential coverage, the Special Enrollment Period includes the 60 days prior to the Triggering Event.

NOTE: If you currently have coverage, the plan for which you are applying must REPLACE the current coverage, but you SHOULD NOT terminate it until the new coverage is effective.