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NATIONAL

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Choice PPO network offers access to over 350,000 dentists nationally.[1,3]

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Select Plan network is one of the largest in the Mid-Atlantic region.[3,4]

To find a participating provider, please visit **DominionNational.com.**

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

VALUE-ADDED BENEFITS

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

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

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DominionNational.com/teledentistry
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1 Dominion National Internal Performance Report, 2022.
2 Networks and products vary by state. Check availability on your state marketplace.
3 Participating providers are subject to change.
4 Managed care plan with exclusive network, fixed member copayments, no annual maximum dollar limits, no waiting periods and no deductibles. In New Jersey, Select Plans are available in Camden, Cumberland and Gloucester counties only. Dominion National Network Analysis Report, 2023. Mid-Atlantic includes D.C., Delaware, Maryland, New Jersey, Pennsylvania and Virginia.
5 Visit DominionNational.com/sdc for full details. Not all individuals are suitable candidates for clear aligners. These services, which are offered and arranged for by SmileDirectClub, are intended for certain individuals who have mild or moderate orthodontic needs and only if approved by a state-licensed dentist or orthodontist. Dominion National is not a provider of dental care services.
6 Visit amplifonusa.com/dn for full details. Hearing services are administered by Amplifon Hearing Health Care Corp.

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

DOMINION® NATIONAL DENTAL

Choice PPO Preventive (MI) Coverage Schedule, Limitations and Exclusions for Adult Services

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	0%	N/A	0%	N/A
3	Major Services	0%	N/A	0%	N/A
4	Orthodontic Services	0%	N/A	0%	N/A

Annual Deductible	In-Network	Out-of-Network
Single Adult	$50	$50
Three or More Adults	$150	$150
Applies To	Class 1	Class 1

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. There is a $50 deductible per adult Member per Calendar Year and the single adult deductible amount must be met prior to satisfying the three or more adults deductible. For three or more adults, the total combined maximum deductible amount for all adult Members is $150 per Calendar Year at which point the deductible is waived for remaining adult Members.

Maximums	In-Network	Out-of-Network
Annual	None	None
Lifetime Orthodontic	N/A	N/A

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, prior review is recommended.

Plan will pay either the Participating Dentist's negotiated fee or the Maximum Allowable Charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations	Two per Calendar Year including a maxmium of one comprehensive evaluation per 36 months	100%	None	Yes	80%	None	Yes
1	Emergency or problem focused exam (D0140)	One per Calendar Year	100%	None	Yes	80%	None	Yes
1	Prophylaxis (cleaning, scaling and polishing teeth)	Two per Calendar Year	100%	None	Yes	80%	None	Yes
1	Bitewing x-rays	One per Calendar Year	100%	None	Yes	80%	None	Yes
1	Emergency palliative treatment	Only if no services other than exam and x-rays were performed on the same date of service	100%	None	Yes	80%	None	Yes
1	Periapical x-rays		100%	None	Yes	80%	None	Yes
1	Full mouth or panoramic x-ray	One per 60 months	100%	None	Yes	80%	None	Yes
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	Yes	80%	None	Yes
2	Simple extraction of teeth		0%	N/A	N/A	0%	N/A	N/A
2	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	0%	N/A	N/A	0%	N/A	N/A
2	Pin retention of fillings	Multiple pins on the same tooth are allowable as one pin	0%	N/A	N/A	0%	N/A	N/A
2	Antibiotic injections administered by a dentist		0%	N/A	N/A	0%	N/A	N/A
3	Oral surgery, including postoperative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty and frenectomy; excision of periocoronal gingiva, exostosis or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/ or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst		0%	N/A	N/A	0%	N/A	N/A
3	Oral surgery, including postoperative care for: coronectomy, intentional partial tooth removal	One per tooth per lifetime	0%	N/A	N/A	0%	N/A	N/A
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: root canal therapy	Not covered if pulp chamber was opened before effective date of coverage	0%	N/A	N/A	0%	N/A	N/A
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: pulpotomy; apicoectomy		0%	N/A	N/A	0%	N/A	N/A

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Endodontic treatment of disease of the tooth, pulp, root and related tissue, limited to: retrograde fillings	One per root per lifetime	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: periodontal maintenance	Two per Calendar Year following surgery	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: scaling and root planing	One per quadrant per 24 months from age 21	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: occlusal adjustment performed with covered surgery		0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: gingivectomy; osseous surgery including flap entry and closure		0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: pedicle or free soft tissue graft	One per site per lifetime	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: occlusal guard (night guards)	One per 5 years within 6 months of osseous surgery	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: full mouth debridement	One per lifetime	0%	N/A	N/A	0%	N/A	N/A
3	Periodontic services, limited to: scaling in presence of generalized moderate or severe gingival inflammation	Full mouth, after oral evaluation and in lieu of a covered D1120/D1110, limited to one per two years	0%	N/A	N/A	0%	N/A	N/A
3	Study model	One per 36 months	0%	N/A	N/A	0%	N/A	N/A
3	Crown build-up for non-vital teeth		0%	N/A	N/A	0%	N/A	N/A
3	Recementing bridges, inlays, onlays and crowns	After first 12 months of insertion and per 12 months per tooth thereafter	0%	N/A	N/A	0%	N/A	N/A
3	Repair of dentures or fixed bridgework	One per 24 months	0%	N/A	N/A	0%	N/A	N/A
3	General anesthesia and analgesia, including intravenous sedation	Covered in conjunction with covered oral surgery, or periodontal surgery	0%	N/A	N/A	0%	N/A	N/A
3	Infiltration of sustained release therapeutic drug, per quadrant		0%	N/A	N/A	0%	N/A	N/A
3	Restoration services, limited to: 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	0%	N/A	N/A	0%	N/A	N/A
3	Restoration services, limited to: replacement of existing inlay, onlay, or crown	After 7 years of the restoration initially placed or last replaced	0%	N/A	N/A	0%	N/A	N/A
3	Restoration services, limited to: post and core	Covered in addition to a crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally	0%	N/A	N/A	0%	N/A	N/A

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	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	One per two years	0%	N/A	N/A	0%	N/A	N/A
3	Prosthetic services, limited to: initial placement of removable dentures or fixed bridges		0%	N/A	N/A	0%	N/A	N/A
3	Prosthetic services, limited to: replacement of removable dentures or fixed bridges	That cannot be repaired after 7 years from the date of last placement	0%	N/A	N/A	0%	N/A	N/A
3	Prosthetic services, limited to: addition of teeth to existing partial denture		0%	N/A	N/A	0%	N/A	N/A
3	Prosthetic services, limited to: relining or rebasing of existing removable dentures	One per 24 months (only after 24 months from date of last placement)	0%	N/A	N/A	0%	N/A	N/A
4	Orthodontia Services Not Covered	Diagnostic services, active and retention treatment to include removable fixed appliance therapy and limited and comprehensive therapy	0%	N/A	N/A	0%	N/A	N/A

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth including third molars.
12. Services not listed as covered.
13. 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.
14. Services for increasing vertical dimension or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate, malignancies or neoplasms.
18. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 12 months of Member's continuous coverage under the plan.

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

DOMINION® NATIONAL DENTAL

Choice PPO Basic *Kids* (MI) Coverage Schedule, Limitations and Exclusions for Pediatric Services

Coverage continues through end of the year in which the Member turns 19

Service Class	Service Description	In-Network		Out-of-Network	
		Plan Pays	Waiting Period	Plan Pays[1]	Waiting Period
1	Diagnostic & Preventive Services	100%	None	80%	None
2	Basic Services	35%	None	20%	None
3	Major Services	25%	None	10%	None
4	Orthodontic Services	0%	None	0%	None

Annual Deductible	In-Network	Out-of-Network
Single Child	$100	$100
Two or More Children	$200	$200
Applies To	Class 2 and Class 3	Class 2 and Class 3

- Each member must pay the combined in and out-of-network deductible amount for dental services before the plan will begin to cover the member's dental procedures. For two or more children, the total combined maximum deductible amount for all pediatric members is $200 per Calendar Year at which point the deductible is waived for remaining pediatric members.
- The single child deductible amount must be met by one child prior to satisfying the two or more children deductible amount.

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

- The annual Out-of-Pocket Maximum for In-Network Covered Services applies to all In-Network Covered Services.
- There is no annual Out-of-Pocket Maximum for Out-of-Network Covered Services. Member is responsible for all Coinsurance, Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network Covered Services.
- The Single Child amount must be met by one child prior to satisfying the Two or More Children amount.

Out-of-Network Allowance	In-Network	Out-of-Network
	N/A	MAC

1. Unlike in-network (INN) providers that have agreed to negotiated fees for services, out-of-network (OON) providers have no contract with Dominion or Dominion's leased dental networks. As such, OON providers set their own fees and Dominion only reimburses the member based on the established INN fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the OON provider's fee is higher than Dominion's INN fee schedule, the member will be billed the remaining balance to cover the OON provider's fee.

- If course of treatment is to exceed $300, pre-authorization is required.

Plan will pay either the Participating Dentist's negotiated fee or the Maximum Allowable Charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
1	Evaluations, examinations or limited problem focused re-evaluations	Limited to two (2) per Calendar Year	100%	None	No	80%	None	No
1	Limited oral evaluation - problem focused or emergency oral evaluation		100%	None	No	80%	None	No
1	Comprehensive oral evaluation		100%	None	No	80%	None	No
1	Prophylaxis/cleaning	Limited to three (3) per Calendar Year	100%	None	No	80%	None	No
1	Fluoride treatment, topical application		100%	None	No	80%	None	No
1	Bitewing x-rays	Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit; one set per Calendar Year	100%	None	No	80%	None	No
1	Intraoral periapical or occlusal images	Not on the same date of service as a panoramic radiograph	100%	None	No	80%	None	No
1	Full mouth, complete series or panoramic radiograph	Limited to one per 60 months	100%	None	No	80%	None	No
1	Space maintainer	Space maintainer to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer	100%	None	No	80%	None	No
1	Sealants or preventive resin restorations	Limited to permanent molar teeth without restorations or decay	100%	None	No	80%	None	No
1	Teledentistry, synchronous (D9995) or asynchronous (D9996)	Must be accompanied by a covered procedure	100%	None	No	80%	None	No
2	Amalgam and composite fillings		35%	None	Yes	20%	None	Yes
2	Pin retention of fillings		35%	None	Yes	20%	None	Yes
2	Protective restoration		35%	None	Yes	20%	None	Yes
2	Consultations	Diagnostic service provided by dentist or physician other than requesting dentist or physician	35%	None	Yes	20%	None	Yes
2	Crown build-up for non-vital teeth		35%	None	Yes	20%	None	Yes
2	Cast and prefabricated post and core	Coverage in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and peridontally	35%	None	Yes	20%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
2	Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown		35%	None	Yes	20%	None	Yes
2	Emergency palliative treatment or after-hours office visit	Only if no services other than exam and x-rays were performed on the same date of service	35%	None	Yes	20%	None	Yes
2	General anesthesia and analgesic, including intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, and nitrous oxide		35%	None	Yes	20%	None	Yes
2	Recement cast or prefabricated post and core, inlay, onlay, crown		35%	None	Yes	20%	None	Yes
2	Pulp vitality tests		35%	None	Yes	20%	None	Yes
2	Diagnostic casts		35%	None	Yes	20%	None	Yes
2	Accession of tissue, gross and microscopic examination, preparation and transmission of written report		35%	None	Yes	20%	None	Yes
3	Oral surgery, including postoperative care for:	Removal of teeth, including impacted teeth; extraction of tooth root; alveoplasty, per quadrant; excision of periocoronal gingiva, per tooth; removal of exostosis, per site; incision and drainage of an abscess or cyst; surgical access of an erupted tooth; excision of hyperplastic tissue; biopsy of soft tissue; brush biopsy	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Tooth re-implantation and/or stabilization	25%	None	Yes	10%	None	Yes
3	Oral surgery, including postoperative care for:	Buccal/labial and lingual frenectomy, frenulectomy	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Root canal therapy; and retreatment of previous root canal therapy	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulp caps, pulpotomy (only when root canal therapy is not the definitive treatment) and pulpal debridement; root amputation	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Pulpal therapy limited to primary teeth only	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Treatment of root canal obstruction, no surgical access	25%	None	Yes	10%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Incomplete endodontic therapy, inoperable or fractured tooth	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Internal root repair of perforation defects	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Apexification/recalcification for permanent and primary teeth; apicoectomy/ periradicular surgery	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Retrograde fillings	25%	None	Yes	10%	None	Yes
3	Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:	Hemisection, including any root removal	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Periodontal maintenance	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Scaling and root planing, once per 24 months per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingivectomy or gingivoplasty	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Gingival flap procedure, including scaling and root planing, per quadrant	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Clinical crown lengthening, hard tissue	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Apically positioned flap	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Provisional splinting	25%	None	Yes	10%	None	Yes
3	Periodontic services, limited to:	Full mouth debridement	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Cast metal, resin-based, porcelain/ceramic, titanium inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Labial veneer	25%	None	Yes	10%	None	Yes
3	Restoration services, limited to:	Crown and bridge repair	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Initial placement of fixed bridges including bridge abutments and pontics; each abutment and pontic makes up a unit in a bridge	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Initial placement of complete, immediate or partial dentures; repair and adjustment of dentures; addition of teeth or clasp to existing partial denture	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Rebase or reline complete or partial denture	25%	None	Yes	10%	None	Yes
3	Prosthetic services, limited to:	Recementing or repairing fixed partial denture	25%	None	Yes	10%	None	Yes

Service Class	Service Description	Service Limitation	In-Network			Out-of-Network		
			Plan Pays	Waiting Period (Months)	Does a deductible apply?	Plan Pays	Waiting Period (Months)	Does a deductible apply?
3	Prosthetic services, limited to:	Tissue conditioning	25%	None	Yes	10%	None	Yes
3	Infiltration of sustained release therapeutic drug, per quadrant		25%	None	Yes	10%	None	Yes
4	Orthodontia Services:	Not Covered	0%	None	No	0%	None	No

Plan Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not medically necessary for the patient's dental health.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services related to the treatment of TMD (Temporomandibular Disorder).
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review.
12. Services not listed as covered.
13. Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function.
14. Services for increasing vertical dimension or replacing tooth structure lost by attrition.
15. Services for correcting developmental malformations and/or congenital conditions beyond the extent that an otherwise covered dental service is provided.
16. Procedures that are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
17. Treatment of cleft palate (if not treatable through orthodontics).
18. Treatment of malignancies or neoplasms.
19. Orthodontia services are not covered.