Dental disease is preventable. Dominion plans encourage the early detection of dental problems and routine maintenance. We help you take better care of your teeth and now it can cost you less to do it.

Dominion gives you the choice of two different dental options - choose the one that’s right for you and your family.

Choose our Select Plan (same as a DHMO)¹ and use a pre-qualified network dentist, or choose our Access PPO Plan, which allows you to visit any licensed dentist.

When you enroll, membership ID cards and detailed benefit information will be mailed to your home address. The dental benefits you’ve been waiting for are now available!

**We Work For Your Benefit.**

---

¹ Same as a DHMO with fixed member copayments, no annual maximum dollar limits, no waiting periods, no deductibles, no pre-authorization paperwork or pre-treatment estimates and no claim forms (except in the case of out-of-area emergencies).

² Vision plans are underwritten by Avalon Insurance Company [a Dominion affiliate] and are marketed and administered by Dominion Dental Services USA, Inc.

³ Includes DC, Delaware, Maryland, Pennsylvania and Virginia.
Two Unique Dental Programs to Choose From!

Select Plan 703x
Select Plan 703x offers great value and extended coverage for your premium dollar. You must choose a general dentist from our Select Plan dental network. Your general dentist will provide services and charge you according to the Description of Benefits and Member Copayments. If specialty care is required, your general dentist will refer you to a participating specialist who will provide care at a 25% discount.

You will pay any copayments due under the Select Plan directly to your plan dentist at the time of service. There are no claim forms, waiting periods, maximum limits, pre-authorization requirements or deductibles. Over 250 procedures are covered. The complete list of covered procedures will be mailed to you with your membership card. A summary of covered procedures and copayments is included in this brochure.

Select Plan 703x Benefits Include:
- No charge for oral examinations
- No charge for bitewing x-rays
- No charge for topical fluoride for children
- $10 copay for routine semiannual cleanings (children)
- $13 copay for routine semiannual cleanings (adults)
- Additional cleaning covered for expecting mothers and diabetics
- Discount on all implant services

These “no-charge” procedures account for over 65% of dental services most frequently performed for adults, and almost 90% of the most frequently performed services for children.3

You will receive more extensive care (fillings, dentures, crowns, root canals, periodontal care, oral surgery, etc.) at fees 55% to 70% lower than usual and customary charges (please see the Plan Comparison chart).

Orthodontia is also covered for adults and children!

Access PPO Plan
Access PPO is designed to provide members with maximum access to dentists. Members may seek dental services from any licensed dentist or use a participating Access PPO network dentist for greater coverage at the lowest out-of-pocket cost.

When dental care is received and expenses incurred, payments will be made in accordance with the list of benefits and services in the Coverage Schedule that will be mailed to you with your membership card. A summary of the plans’ benefits can be found in the Plan Comparison in this brochure.

In-Network Access PPO Benefits Include:
- No charge for routine semiannual cleanings
- No charge for oral examinations
- No charge for bitewing x-rays
- No charge for topical fluoride for children

These “no-charge” procedures account for over 65% of dental services most frequently performed for adults, and almost 90% of the most frequently performed services for children.3

More extensive care (fillings, dentures, crowns, root canals, periodontal care, oral surgery, etc.) is covered at increasing levels, progressing through years 1, 2 and 3 (please see the Plan Comparison chart).

There is an annual deductible of $50 per insured person (family maximum of $150) applicable to all services. A maximum benefit of $1,000 per calendar year, per insured person will be paid.

There are no waiting periods under the Access PPO plan.

---

1 Same as a DHMO with fixed member copayments, no annual maximum dollar limits, no waiting periods, no deductibles, no pre-authorization paperwork or pre-treatment estimates and no claim forms or proof of loss (except in the case of out-of-area emergencies).
2 Out-of-area emergency care reimbursement requires a receipt or other proof of loss
3 Dental Services, Inc. - based on annual review of utilization data.
### Plan Comparison

#### Rates

<table>
<thead>
<tr>
<th></th>
<th>Select Plan 703x</th>
<th>Access PPO Plan 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Premium</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>$16.14</td>
<td>$29.86</td>
</tr>
<tr>
<td></td>
<td>$19.36</td>
<td>$32.27</td>
</tr>
<tr>
<td><strong>Member + 1</strong></td>
<td>$29.84</td>
<td>$64.10</td>
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<tr>
<td></td>
<td>$35.82</td>
<td>$69.28</td>
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<tr>
<td><strong>Member + 2 or More</strong></td>
<td>$44.42</td>
<td>$92.77</td>
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<tr>
<td></td>
<td>$51.04</td>
<td>$100.27</td>
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#### Procedures and Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Select Plan 703x</th>
<th>Access PPO Plan 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic and Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral exams</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Topical fluoride for children</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Teeth cleanings [amount per year]</td>
<td>85% (2)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full and panoramic X-rays</td>
<td>60-75%</td>
<td>100%</td>
</tr>
<tr>
<td>Fillings</td>
<td>45%</td>
<td>40%</td>
</tr>
<tr>
<td>Amalgam [silver]</td>
<td>70%</td>
<td>40%</td>
</tr>
<tr>
<td>Composite [white]</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Extraction, erupted tooth</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Major Restorative Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetics</td>
<td>55-70%</td>
<td>15%</td>
</tr>
<tr>
<td>Crowns and bridges</td>
<td>55%</td>
<td>25%</td>
</tr>
<tr>
<td>Dentures</td>
<td>60%</td>
<td>25%</td>
</tr>
<tr>
<td>Relining of dentures</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>60%</td>
<td>15%</td>
</tr>
<tr>
<td>Root planing and therapy</td>
<td>55%</td>
<td>25%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>70%</td>
<td>25%</td>
</tr>
<tr>
<td>Root canals</td>
<td>70%</td>
<td>25%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>60%</td>
<td>15%</td>
</tr>
<tr>
<td>Extraction of impacted teeth</td>
<td>55%</td>
<td>25%</td>
</tr>
<tr>
<td>Implants</td>
<td>15% discount</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children and adults</td>
<td>45%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Benefit Features</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$10</td>
<td>None</td>
</tr>
<tr>
<td>Deductibles</td>
<td>None</td>
<td>$50 per insured person*4 ($150 family maximum)</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>None</td>
<td>$1,000 per insured person</td>
</tr>
<tr>
<td>Waiting Periods</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Claim Forms</td>
<td>None</td>
<td>Access PPO network dentist or any licensed dentist</td>
</tr>
<tr>
<td>Receive Care From</td>
<td>Select Plan Network Dentist</td>
<td></td>
</tr>
</tbody>
</table>

1. Provided by Dominion Dental Services, Inc. Approximate percentage of coverage based on the Captiva Context Fee Schedule’s 80th percentile. A specific fee schedule applies and will be mailed with your membership card. Please see the Summary of Member Fees inside the brochure for a sample of member fees.
2. Out-of-area emergency care reimbursement requires a receipt or other proof of loss.
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. Deductibles apply to all services.
<table>
<thead>
<tr>
<th>Diagnostic/Preventive</th>
<th>Member Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9439 Office visits</td>
<td>$10</td>
</tr>
<tr>
<td>D0150 Oral examinations and diagnosis</td>
<td>No Charge</td>
</tr>
<tr>
<td>X-rays:</td>
<td></td>
</tr>
<tr>
<td>D0210 Complete series</td>
<td>.26</td>
</tr>
<tr>
<td>D0239 Single periapical</td>
<td>No Charge</td>
</tr>
<tr>
<td>D0270 Bitewing</td>
<td>No Charge</td>
</tr>
<tr>
<td>D0330 Panoramic x-rays</td>
<td>.30</td>
</tr>
<tr>
<td>D0250/60 Each film</td>
<td></td>
</tr>
<tr>
<td>D0490 Pulp vitality test</td>
<td>No Charge</td>
</tr>
<tr>
<td>D0470 Diagnostic models</td>
<td>No Charge</td>
</tr>
<tr>
<td>D1120 Teeth cleaning [one per 6 months per member - adult]</td>
<td>.10</td>
</tr>
<tr>
<td>D1119 Teeth cleaning [one per 6 months per member - child]</td>
<td>.10</td>
</tr>
<tr>
<td>D1121 Additional cleaning [expecting mothers or Diabetics]</td>
<td>.19</td>
</tr>
<tr>
<td>D1203/04 Topical fluoride</td>
<td>No Charge</td>
</tr>
<tr>
<td>D1310 Nutritional counseling</td>
<td>No Charge</td>
</tr>
<tr>
<td>D1320/00 Oral hygiene instruction</td>
<td>No Charge</td>
</tr>
<tr>
<td>D1351 Sealant - per tooth [up to age 14]</td>
<td>.21</td>
</tr>
</tbody>
</table>

**Space Maintainers:**

D1510/20 Unilateral                  | 143         |
D1525/20 Bilateral                 | 198         |
D1550 Recementation               | .34         |
D1110 Emergency (post operative) | No Charge   |
D2910/15 Local anaesthesia       | No Charge   |
D9320 Nitrous oxide [per visit - if available] | .33         |
D9310 Second opinion/consultation, per session [by another plan dentist] | .23         |
D9990 Broken appointments        | 50          |

**Refractive Dentistry [Fillings]:**

Amalgam restorations (silver):

D2140 One surface filling, primary/permanent | .41         |
D2150 Two surfaces filling, primary/permanent | .66         |
D2160 Three surfaces filling, primary/permanent | .64         |
D2161 Four or more surfaces filling, primary/permanent | .78         |

Resin composite restorations (tooth colored):

D3230 One surface filling, anterior | .69         |
D3231 Two surface filling, anterior | .58         |
D3232 Three surface filling, anterior | .99         |
D3233 Four or more surface filling, anterior | 119         |
D3250 Pin retention (per tooth, add to restoration) | .32         |
D3110/20 Pulp cap [direct/indirect] [final restoration] | .32         |
D2940 Satisfactory correction | 39          |

**Crowns & Bridge**

Crown & Bridge (Caps, Fixed Tooth Replacement)

D2510 Inlay - one surface | .407         |
D2524 Onlay - two surface | .458         |
D2790 Resin crowns (lab processed) | .458         |
D2970 Temporary crown (fractured tooth) | No Charge |
D2200/2122 Resin with metal crown | .495         |
D2790/91/92 Porcelain crown fused to metal | .523         |
D2790/91/92 Full cast crown | .495         |
D2910/10 Recementation: inlay/crown per unit | .53         |
D2952 Cast post and core in addition to crown | .166        |
D2954 Prefabricated post and core in addition to crown | .166        |
D2991 Stainless steel crown (palladium) | .166        |
D2990 Core buildup, including any pins | .125         |
D2980 Crown repair, by report | .102         |

**Ponics**

D6000-Dx199 ALL IMPLANT SERVICES - 15% DISCOUNT incl. D0360-D0363 cone beam imaging w/ implants | .495         |
D2610/1721 Cast (metal) | .495         |
D2620/1721 Porcelain with metal | .523         |
D6250/1625 Resin with metal | .495         |

**Bridge Retainers**

D5450 Retainer - cast metal for resin bonded fixed bridge | .251         |
D6780 Crown - 3/4 cast noble metal | .470         |

**Prosthetics (Removable)**

D5110/20 Complete denture - upper or lower | .677         |
D5130/40 Immediate denture - upper or lower | .722         |

**Partial Denture**

D5112/11 Upper/lower - resin base | .649         |
D5121/13 Upper/lower - cast metal | .750         |
D2280 Removable partial - one piece cast metal | .416         |
D5810/11 Interim complete denture - maxillary/mandibular | .362         |
D5410/11 Adjust complete denture - maxillary/mandibular | .38         |
D2970 Resin complete maxillary/mandibular denture (lab) | .149         |
D5100/5610 Repair broken denture base [complete/resin] | .87         |
D5330 Replace missing or broken teeth - complete denture | .87         |

**Endodontics**

D3220 Pulpotomy | .81         |
D3100 Anterior | .416         |
D3320 Bicuspids | .416         |
D3330 Molar | .512         |
D3410 Apicoectomy - anterior | .323         |
D3421 Apicoectomy - bicuspid (first root) | 364         |
D3425 Apicoectomy - molar (first root) | 418         |
D3426 Apicoectomy - (each additional root) | 152         |

**Periodontics**

D4210 Gingivectomy per quadrant [four or more teeth] | .279         |
D4220 Gingivectomy per quadrant [one to three teeth] | .100         |
D4241 Gingival flap surgery per quadrant [one to three teeth] | .106         |
D4341 Periodontal scaling and root planing per quadrant [four or more teeth] | .109         |
D6290 Each additional film | .74         |

**Oral Surgery**

D4210 Extraction, without complication | .56         |
D7210 Incisional, excisional, erupted, impacted | .133         |
D7220 Soft tissue | .151         |
D7230 Partially bony | .196         |
D7250 Surgical removal of residual tooth roots | .141         |

*This is only a summary of the 250+ procedures that are covered. Please visit Teethkeepers.com for a complete list of covered procedures.*

---

**Select Plan 703x Plan Exclusions**

1. Services which are covered under Medicare, worker’s compensation, employer’s liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law (Pennsylvania policyholders only).
2. Services which, in the opinion of the attending dentist, are not necessary for the patient’s dental health.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary congenital, 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.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services listed as excluded from this Plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or Dominion Dental Services, Inc (with the exception of out-of-area emergency dental services).
12. Services performed by an associated general dental office in the same building.
13. Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating General Dentist. Absent in cooperating with a Participating Specialist (with the exception of orthodontics). Participating Specialists, if available, have entered into an agreement with Dominion Dental Services to provide dental services to members at a 25% reduction from their usual, customary and reasonable (UCR) fees. In Delaware, Participating Specialists will provide a reduction from their UCR that will vary between specialists.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
15. The invisible orthodontic appliance -- 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.

**Select Plan 703x Plan Limitations**

1. Two (2) teeth restorations are covered per calendar year including a maximum of one (1) comprehensive evaluation.
2. One (1) emergency or problem focused exam is covered per calendar year.
3. Two (2) fillings + (prophylaxis) are covered per calendar year (one additional cleaning is covered during pregnancy and for diabetic patients).
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. One (1) sealant or preventative resin restoration per tooth is covered per lifetime, up to age 16 (limited to permanent 1st and 2nd molars).
8. Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. 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%.
11. Relining and relining of dentures is covered once every 24 months.
12. Replacement of root canal is covered if it is more than two (2) years from the original treatment.
13. Two (2) crowns or bridges are covered per calendar year in addition 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.
14. Periodontal surgery of any type, including any associated material, is covered once every thirty (30) months per quadrant or surgical site.
15. Periodontal maintenance after surgical therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc Current Dental Terminology © American Dental Association.
The Access PPO plan will pay the applicable percentage of usual and customary charges for covered dental procedures and services after any required deductible amount is met, as shown below:

- If the course of treatment is to exceed $300, prior review is requested.
- Services may be received from any licensed dentist.
- There are no waiting periods.
- Services may be received from any licensed dentist.
- If the course of treatment is to exceed $300, prior review is requested.

Class I. Diagnostic & Preventive Services Include:
1. Two evaluations per calendar year including a maximum of one comprehensive evaluation;
2. One emergency or problem focused exam (D0140) per calendar year;
3. Two prophylaxis (cleaning, scaling and polishing teeth) per calendar year;
4. One topical fluoride per calendar year, to age 16;
5. Bite-wing x-rays, 2 per calendar year;
6. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).

Class II. Basic Services Include:
1. Simple extraction of teeth;
2. Amalgam and composite fillings (restorations of mesiogingual, distogingual, mesibuccal, and distobuccal surfaces considered single surface restorations);
3. Periapical x-rays;
4. One diagnostic x-ray, full or panoramic per 36 months;
5. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin);
6. Antibiotic injections administered by a dentist;
7. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).

Class III. Major Services Include:
1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth;
   b. Extraction of tooth root;
   c. Alveolotomy, alveoplasty, and frenectomy;
   d. Excision of pericoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy;
   e. Replantation or transplantation of a natural tooth;
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
2. 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;
   d. Retrograde fillings.
3. Periodontic services, limited to:
   a. Two periodontal cleanings following surgery per calendar year (D4341 is not considered surgery);
   b. One root scaling and planing, once per quadrant of mouth per 6 months;
   c. Occlusal adjustment, performed with covered surgery;
   d. Gingivectomy and gingival curettage;
   e. Osseous surgery including flap entry and closure;
   f. Pedicle or free soft tissue graft;
   g. One appliance (night guard) in 5-years.
4. One study model per 36 months;
5. Crown build-up for non-vital teeth;
6. Recementing bridges, inlays, onlays and crowns;
7. One repair of dentures or fixed bridgework per 24 months;
8. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery; periodontal surgery.
9. Restoration services, limited to:
   a. Gold or porcelain inlays, onlays, and crowns for 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 5 years of the restoration initially placed or last replaced (Will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage);
   c. Stainless steel crowns;
   d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally.
10. Prosthetic services, limited to:
   a. Initial placement of dentures or fixed bridgework (including acid etch metal bridges);
   b. Replacement of dentures or fixed bridgework that cannot be repaired after 5 years from the date of last placement;
   c. Addition of teeth to existing partial denture;
   d. One relining or rebasting of existing removable dentures per 24 months (only after 12 months from date of last placement).

Class IV. Orthodontia Services:
Not covered under this plan.

ACCESS PPO PLAN EXPENSES NOT COVERED:
No benefits will be paid for expenses incurred:
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.
3. Services and treatment provided without charge or for which there would be no charge in the absence of insurance.
4. Services not listed as covered.
5. Hospitalization for any dental procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
8. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
9. Replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
11. Services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
12. Oral hygiene instructions; plaque control; completion of a claim form; acid etch; broken appointments; prescription or take-home fl uoride; or diagnostic photographs.
13. Dispensing of drugs.
14. Diagnosis or treatment of temporomandibular joint (TMJ) syndromes, problems and/or occlusal disharmony.
15. Procedures that in the opinion of Dominion Dental Services are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, anodontia, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.
18. Maryland policyholders only. Any bill, or demand for payment, for a dental 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.

* Percent of usual and customary charges paid by carrier after any deductible is met.

** Year 1 benefits apply during the first 12 months of continuous coverage. Year 2 benefits apply during the second 12 months of continuous coverage and Year 3 benefits apply during the third 12 months of continuous coverage.
**Who is Eligible?**

You and your dependents are eligible. Dependents include your spouse and unmarried children up to age 26.

**How do I Join?**

1. To pay annually by check, complete the Enrollment Card and submit it with a check for 12 months of premium. Go to Step 3.

2. To pay by debit to your checking account or credit card account, please fill out the Payment Authorization Card. Be sure to select either the automatic monthly debit option or annual payment option.
   - 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 Payment Authorization Card when selecting this option.
   - When you choose the annual payment option you will be charged (debited) one time for 12 months of premium.
   - There is a minimum participation requirement of one year.

3. Fill out the Enrollment Card. Be sure to list all dependents you want covered. Additional dependents can be listed on the back of the Enrollment Card, if necessary.
   - Select either the Discount Program, Select Plan or Access PPO Plan.
   - If you choose either the Discount Program or the Select Plan, please select a dentist and fill in the Dental Office Name & Code # box.
   - Sign and date the appropriate section of the Enrollment Card.

4. Return the completed Enrollment Card, Payment Authorization Card (if applicable) or payment (if applicable) to:
   
   **Dominion Dental Services, Inc.**
   
   P.O. Box 75314
   
   Charlotte, NC 28275-5314

   - A Membership Card and coverage information will be mailed to you on or before your first day of eligibility.

**THERE IS NO ENROLLMENT FEE!**

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The following explanation as required by the Maryland Insurance Administration.

**Select Plan Premium Dollar Distribution**

Dominion is licensed as a Dental Plan Organization (DPO) in the State of Maryland. 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 2011 between dentist compensation and administration costs.

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**Teethkeepers.com/eHealth**

115 South Union Street, Suite 300
Alexandria, VA 22314
888-518-5338 (Phone)
703-518-0627 (Fax)
DominionDental.com
Payment Authorization Card

Our Pre-authorized Payment Plan
Just authorize us to debit your personal checking account or credit card account and we’ll do the rest. Whether you choose the monthly or annual option with automatic deductions there will be no more paperwork, no more checks to write and no worries about coverage disruption. It’s easy, secure, and automatic.

Pay By Credit Card Debit: ❑ Automatic Monthly Debits ❑ Annual Payment
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 ❑ Annual Payment
Bank Name: ____________________________
Bank Routing Number: ____________________________
Bank Account Number: ____________________________

* By submitting a check for the first month’s premium and application fee, you authorize Dominion Dental Services, Inc. to automatically deduct future monthly premium payments from your checking account.

Terms and Authorization
Payment Authorization: By signing the Payment Authorization form you authorize Dominion Dental Services Inc. to automatically deduct premium payments from the credit card or checking account noted above. By selecting the Automatic Monthly Debits option you further agree to automatic deductions of future monthly premiums.

Application Fee: There is a one-time, non-refundable $20 application and processing fee. When paying by Automatic Monthly Debit to your checking account or credit card account, you will be charged the application fee along with your first month’s premium. When paying by Annual Payment you will be charged for 12 months of premium plus the $20 application fee. THERE IS NO APPLICATION FEE!

Pay By Credit Card: By selecting the Automatic Monthly Debits option you authorize Dominion Dental Services Inc. to automatically deduct future monthly premium payments from your credit card account.

Pay By Bank Account Debit: By selecting the Automatic Monthly Debits and submitting a voided check you authorize Dominion Dental Services Inc. 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 Dental Services, Inc. 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: I authorize Dominion Dental Services, Inc. to automatically deduct the premium and application fee from any credit card or bank account stated above. Members who choose the Automatic Monthly Debits will be debited on or about the 20th of each month (subscribers enrolling in Maryland will be debited on or after the 1st of each month).

Signature: ____________________________ Date: ____________________________

Agent/Broker Use Only
Agent/Broker #: ____________________________ General Agent #: ____________________________

Go to next page for enrollment form.