



Take care of your teeth with Dominion Dental Services



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.

Dominion Dental Services (Dominion) is a leading administrator of dental and vision² benefits in the Mid-Atlantic.³ Among our nearly 500,000 customers are leading health plans, employer groups, municipalities, associations and individuals.

- 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 703x¹

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,² 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		Select Plan ¹ 703x		Access PPO Plan 1					
		DC,MD,PA,VA	DE	Area 1	Area 2	Area 3	Area 4		
Monthly Premium	Member	\$16.14	\$19.36	\$29.86	\$32.27	\$33.46	\$38.33		
	Member + 1	\$29.84	\$35.82	\$64.10	\$69.28	\$71.83	\$82.28		
	Member + 2 or More	\$44.42	\$51.04	\$92.77	\$100.27	\$103.97	\$119.09		
Procedures and Covered Services				In-Network			Out-of-Network		
				Year 1 ³	Year 2 ³	Year 3 ³	Year 1 ³	Year 2 ³	Year 3 ³
Diagnostic and Preventive Care		100%		100%	100%	100%	90%	90%	90%
Oral exams		100%		100%	100%	100%	90%	90%	90%
Bitewing X-rays		100%		100%	100%	100%	90%	90%	90%
Topical fluoride for children		100%		100%	100%	100%	90%	90%	90%
Teeth cleanings (amount per year)		85% (2)		100% (2)	100% (2)	100% (2)	90% (2)	90% (2)	90% (2)
Basic Care		60-75%		40%	60%	80%	30%	50%	70%
Full and panoramic X-rays		45%		40%	60%	80%	30%	50%	70%
Fillings									
Amalgam (silver)		70%		40%	60%	80%	30%	50%	70%
Composite (white)		60%		40%	60%	80%	30%	50%	70%
Extraction, erupted tooth		60%		40%	60%	80%	30%	50%	70%
Major Restorative Care		55-70%		15%	25%	50%	10%	20%	40%
Prosthetics									
Crowns and bridges		55%		15%	25%	50%	10%	20%	40%
Dentures		60%		15%	25%	50%	10%	20%	40%
Relining of dentures		50%		15%	25%	50%	10%	20%	40%
Periodontics									
Root planing and therapy		60%		15%	25%	50%	10%	20%	40%
Endodontics									
Root canals		70%		15%	25%	50%	10%	20%	40%
Oral Surgery									
Extraction of impacted teeth		55%		15%	25%	50%	10%	20%	40%
Implants		15% discount		0%	0%	0%	0%	0%	0%
Orthodontics		45%		0%	0%	0%	0%	0%	0%
Children and adults		45%		0%	0%	0%	0%	0%	0%
Benefit Features									
Office Visit		\$10		None					
Deductibles		None		\$50 per insured person ⁴ (\$150 family maximum)					
Annual Maximum		None		\$1,000 per insured person					
Waiting Periods		None		None					
Claim Forms		None ²		Yes					
Receive Care From		Select Plan Network Dentist		Access PPO network dentist or any licensed dentist					

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.

Select Plan 703x Summary of Benefits and Member Copayments*

Diagnostic/Preventive		Member Fees
D9439	Office visits	\$10
D0150	Oral examinations and diagnosis	No Charge
	X-rays:	
D0210	Complete series	.26
D0220	Single periapical	No Charge
D0270	Bitewing	No Charge
D0330	Panoramic x-rays	.30
D0250/60	Each additional film	No Charge
D0460	Pulp vitality test	No Charge
D0470	Diagnostic models	No Charge
D1110	Teeth cleaning (one per 6 months per member) - adult	.13
D1120	Teeth cleaning (one per 6 months per member) - child	.10
D1110*	Additional cleaning (expecting mothers or Diabetics)	.40
D1203/04	Topical fluoride	No Charge
D1310	Nutritional counseling	No Charge
D1320/30	Oral hygiene instruction	No Charge
D1351	Sealant - per tooth (up to age 14)	.21
	Space Maintainers:	
D1510/20	Unilateral	.143
D1515/25	Bilateral	.198
D1550	Recementation	.34
D9110	Emergency (palliative) treatment per visit	.43
D9210/15	Local anesthesia	No Charge
D9230	Nitrous oxide (per visit - if available)	.37
D9310	Second opinion/consultation, per session (by another plan dentist)	.43
D9990	Broken appointments	.50
Restorative Dentistry (Fillings)		
	Amalgam restorations (silver):	
D2140	One surface filling, primary/permanent	.41
D2150	Two surfaces filling, primary/permanent	.51
D2160	Three surfaces filling, primary/permanent	.64
D2161	Four or more surfaces filling, primary/permanent	.78
	Resin composite restorations (tooth colored):	
D2330	One surface filling, anterior	.69
D2331	Two surface filling, anterior	.83
D2332	Three surface filling, anterior	.99
D2335	Four or more surfaces filling, anterior	1.19
D2951	Pin retention (per tooth, add to restoration)	.22
D3110/20	Pulp cap direct/indirect (excl. final restoration)	.32
D2940	Sedative filling	.39
Crown & Bridge (Caps, Fixed Tooth Replacement)		
D2510	Inlay - one surface	.407
D2542	Onlay - two surface	.458
D2390	Resin crown (lab processed)	.192
D2970	Temporary crown (fractured tooth)	No Charge
D2720/21/22	Resin with metal crown	.495
D2750/51/52	Porcelain crown fused to metal	.523
D2790/91/92	Full cast crown	.495
D2910/20	Recementation: inlay/crown per unit	.43
D2952	Cast post and core in addition to crown	.186
D2954	Prefabricated post and core in addition to crown	.154
D2931	Stainless steel crown (permanent)	.121
D2950	Core buildup, including any pins	.125
D2980	Crown repair, by report	.102
Pontics		
D6000-D6199	ALL IMPLANT SERVICES - 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants)	
D6210/11/12	Cast (metal)	.495
D6240/41/42	Porcelain with metal	.523
D6250/51/52	Resin with metal	.495
Bridge Retainers		
D6545	Retainer - cast metal for resin bonded fixed	.251
D6780	Crown - 3/4 cast high noble metal	.470
Prosthetics (Removable)		
D5110/20	Complete denture - upper or lower	.697
D5130/40	Immediate denture - upper or lower	.722
	Partial Denture:	
D5211/12	Upper/lower - resin base	.649
D5213/14	Upper/lower - cast metal	.750
D5281	Removable unilateral partial - one piece cast metal	.419
D5810/11	Interim complete denture - maxillary/mandibular	.362
D5410/11	Adjust complete denture - maxillary/mandibular	.38
D5750/51	Reline complete maxillary/mandibular denture (lab)	.224
D5510/5610	Repair broken denture base (complete/resin)	.87
D5520	Replace missing or broken teeth - complete denture	.87
Endodontics ¹ (Root Canal)		
D3220	Pulpotomy	.81
D3310	Anterior	.341
D3320	Bicuspid	.418
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 ¹ (Gum Treatment)		
D4210	Gingivectomy per quadrant (four or more teeth)	.279
D4211	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
D4910	Periodontal maintenance	.74

Oral Surgery ¹		
D7111	Extraction, without complication	.56
D7210	Surgical extraction, erupted	.133
	Impaction:	
D7220	Soft tissue	.151
D7230	Partially bony	.196
D7250	Surgical removal of residual tooth roots	.141

¹As performed by a participating General Dentist. See Plan Exclusion # 13.

Orthodontics ²		
D8660	Pre-orthodontic treatment visit	.413
D8080	Two year case (child)	.3,422
D8090	Two year case (adult)	.3,658

² Phase I Treatment (D0810 - D8050) is provided at a 15% reduction from the orthodontist's UCR fees. See exclusion #15 for additional coverage exclusions.

Select Plan 703x Plan Exclusions

- Services which are covered under Medicare, worker's compensation, employer's liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law (Pennsylvania policyholders only).
- Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.
- Oral surgery requiring the setting of fractures or dislocations.
- 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.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- 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.
- Replacement due to loss or theft of prosthetic appliance.
- Procedures not listed as covered benefits under this Plan.
- 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).
- Services related to the treatment of TMD (Temporomandibular Disorder).
- 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 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.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
- 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.

Select Plan 703x Plan Limitations

- Two (2) evaluations are covered per calendar year including a maximum of one (1) comprehensive evaluation.
- One (1) emergency or problem focused exam is covered per calendar year.
- Two (2) teeth cleanings (prophylaxis) are covered per calendar year [one additional cleaning is covered during pregnancy and for diabetic patients].
- One (1) topical fluoride or fluoride varnish is covered per calendar year.
- Two (2) bitewing x-rays are covered per calendar year.
- One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
- One (1) sealant or preventative resin restoration per tooth is covered per lifetime, up to age 16 [limited to permanent 1st and 2nd molars].
- Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
- Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
- 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%.
- Relining and rebasing of dentures is covered once every 24 months.
- Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
- Root planing or scaling is covered once every 24 months per quadrant.
- Full mouth debridement is covered once per lifetime.
- 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.
- Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
- Periodontal maintenance after active 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.

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

Access PPO Plan 1 Description of Benefits

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.

- There is a calendar year deductible of \$50 per insured person applicable to all services. The maximum annual deductible is \$150 per family.
- There is a \$1,000 per calendar year maximum benefit per insured person.
- 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. Bitewing 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).

	In-Network			Out-of-Network		
Class I	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
We Pay*	100%	100%	100%	90%	90%	90%

Class II. Basic Services Include:

1. Simple extraction of teeth;
2. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, 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).

	In-Network			Out-of-Network		
Class I	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
We Pay*	40%	60%	80%	30%	50%	70%

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. Alveolectomy, alveoplasty, and frenectomy;
 - d. Excision of pericoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy;
 - e. Reimplantation 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 guards) 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 rebasing of existing removable dentures per 24 months (only after 12 months from date of last placement).

	In-Network			Out-of-Network		
Class I	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
We Pay*	15%	25%	50%	10%	20%	40%

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 fluoride; 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.

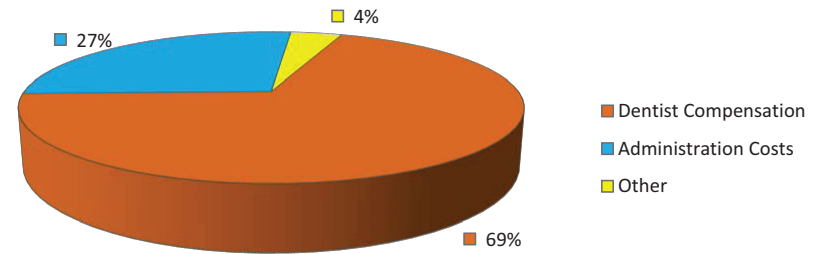
How do I Join?

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!

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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703-518-0627 (Fax)
DominionDental.com

Teethkeepers.com/eHealth

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.

Dominion Dental Services, Inc.
Alexandria, VA

Enrollment Card

SELECT PLAN:

- ☐ Discount Program¹

☐ Access PPO Option 1 (1889)

☐ Select Plan

☐ Access PPO Option 2 (1891)

☐ Access PPO Option 3 (1890)

Enrollment Information

Last Name		First Name		M.I.
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (MM/DD/YY)		
Home Address		Home Phone		
City	State	ZIP	Work Phone	
Email Address				

Does this plan replace other dental coverage? ☐ Yes ☐ No

List All Your Eligible Dependents Below

[illegible]

**SELECT PLAN or
DISCOUNT PROGRAM**

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

If I am enrolling in the Select Plan, I agree to remain in Plan a minimum of twelve (12) months. If I cancel before the end of the 12 month period, I may be responsible for the usual, customary and reasonable charges for services received, reduced by the sum of the subscription dues and copayments paid.

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 dentists and other 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.

Signature _____ Date _____

Agent/Broker #	Group #	Group Name	Coverage Eff. Date
14800000T00	10510000	eHealth	

Dominion Dental Services, 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.

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. District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. 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. 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.