Managed Dental Care Programs

Individual Dental Policy
Select Plan

Dominion Dental Services, Inc. (hereinafter referred to as "Plan") certifies that the Subscriber is covered under and subject to all the provisions, definitions, limitations and conditions of this Individual Dental Policy for the benefits approved herein, and is eligible for benefits stated in the attachments hereto (Description of Benefits and Member Copayments) as of the date indicated in the letter accompanying the Membership Identification Card.

The address of the principal administrative office of Plan is: Dominion Dental Services, Inc., 115 South Union Street, Suite 300, Alexandria, Virginia 22314. The telephone number is (703) 518-5000.

Part I. DEFINITIONS
A. Dependent shall mean lawful spouse of Subscriber and/or unmarried natural, step or adopted children, or children under the Subscriber's legal guardianship, from and after birth up to his/her 26th birthday. Dependent coverage shall include a Domestic Partner of Subscriber and children of a Domestic Partner. Dependent coverage for a spouse's children (if not the Subscriber's children) shall be according to the same terms and conditions as coverage for a Subscriber's children, such coverage shall be according to the same terms and conditions as coverage for a "Spouse" and "Dependents," as the case may be. When a child has been placed with a Subscriber for the purpose of adoption, that child is eligible for Dependent coverage from the date of eligibility, along with proof that the adoption is pending. If a newborn child is placed for adoption with Subscriber within 31 days of birth, such child shall be considered a newborn child of the Subscriber to the same extent as if that child had been a newborn natural child of the Subscriber. An unmarried child who is 26 years, but less than 27, whose time is principally devoted to attending school, and who is dependent upon his parents for primary support, is eligible to be covered as a Dependent. If a Dependent child is enrolled as a full-time student and is unable due to medical condition to continue as a full-time student, coverage for such child shall continue in force for a period of 12 months from the date the child ceases to be a full-time student, or until such child attains age 26, whichever first occurs. The child's treating physician must certify at the time the child withdraws as a full-time student that the child's absence is medically necessary. Upon the attainment of limiting age, coverage as a Dependent shall be extended if the child is and continues to be both (1) incapable of self-sustaining employment by reason of mental or physical incapacity and (2) chiefly dependent upon the Subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to Plan by Subscriber within 31 days of the child's attainment of limiting age and subsequently as may be required by the Plan, but not more than annually after the two-year period following the child's attainment of limiting age. Subject to a valid court order requiring coverage of a child under this Plan, (i) the parent subject to the court order ("insuring parent") and the child may enroll in the Plan under the parent's policy; or (ii) the Plan shall allow the non-insuring parent, child support enforcement agency or MD Dept. of Health and Mental Hygiene to apply for enrollment for the child. Enrollment period restrictions shall not apply to an order.

B. Domestic Partner shall mean a person who is at least 18 years old, is not related to Subscriber by blood or marriage within four degrees of consanguinity under civil law rule, is not married or in a civil union or domestic partnership with another individual, has been financially interdependent with Subscriber for at least 6 consecutive months prior to enrollment in Plan in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely, and shares a primary residence with Subscriber. In order to obtain coverage for a Domestic Partner, Subscriber must sign an Affidavit of Domestic Partnership form provided by the Plan.

C. Member shall mean any individual Subscriber or eligible family

D. Participating Dentist shall mean those independent licensed dentists who have contracted with the Plan to provide dental services for Members of the Plan. Participating Dentists are not employees of, nor supervised by the Plan.

E. Plan Specialist shall mean those independent licensed specialists who have contracted with the Plan to provide dental services for Members of the Plan that are of such a degree of complexity as not to be normally performed by a Participating Dentist. Plan Specialists are not employees of, nor supervised by the Plan.

F. Subscriber shall mean an individual in good standing who has paid the Subscription Dues for services of the Plan prior to the period of eligibility, including payments for Dependents as hereinafter defined.

G. Subscription Dues shall mean amounts payable on a regular prepayment basis by or for the Subscriber to the Plan.

H. Usual and Customary Fees shall mean those fees that the Participating Dentist usually charges for dental services when a person is not affiliated with any dental program.

Dominion Dental Services, Inc.
115 S. Union Street
Suite 300
Alexandria • Virginia • 22314
(703) 518-5338
Toll Free (888) 518-5338
Part II. EFFECTIVE DATE OF BENEFITS
A. All persons, who have enrolled in the Plan and paid the appropriate Subscription Dues on or before the 17th day of the month, shall be eligible for benefits commencing on the 1st day of the following month.
B. All persons who have enrolled in the Plan and paid the appropriate Subscription Dues between the 17th day of the month and the last day of the month shall be eligible for benefits commencing on the 1st day of the second month.
C. The effective date of benefits for all Subscribers and enrolled Dependents, as described in Part II. A and B, will be indicated in the letter accompanying their Membership Identification Card.

Part III. TERMINATION OR CANCELLATION
Benefits shall cease upon the earliest of the following events:
A. On the date of expiration of the period for which the last payment of Subscription Dues was made to Plan. If payment is not made in full on or prior to the date due, as specified in Part IV-A, a grace period of 31 days from the last date of coverage shall be granted to the Subscriber after the first payment. The Contract shall remain in full force and effect during the grace period.
B. Upon the date of Dependents attaining the age of 26 years or marriage prior to that date (Subject to Part I-A).
C. If after reasonable efforts to establish and maintain a satisfactory dentist-patient relationship, the Participating Dentist is unable to do so, the Plan reserves the right to transfer the Subscriber and Dependents to a second and then third Participating Dentist of their choice. If the third Participating Dentist is also unable to establish a satisfactory dentist-patient relationship, the Plan reserves the right to terminate the membership of said Subscriber and Dependents. Termination shall be effective on the last day of the month after 31 days of which termination notice occurs. In case of termination by the Plan, and if services have been rendered, no refund will be given to Subscriber.
D. Upon breach of any term or condition herein, fraud or deception in the use of services, coverage will be canceled after the 31st day after written notice is mailed to the Subscriber.

Upon termination of coverage, an extension of benefits shall be provided for any treatment in progress at the time of termination, provided the treatment requires two or more visits on separate days to the dentist's office. Extension of benefits will be limited to 90 days for all care other than orthodontics, and 60 days for orthodontics if the orthodontist has agreed to or is receiving monthly payments when coverage terminates, or to the end of the quarter in progress or 60 days, whichever is longer, if the orthodontist is receiving quarterly payments. An extension of benefits will not be provided if termination was due to a failure to pay the Subscription Dues or fraud or deception in the use of services. Subject to Part III, A through D, Subscriber must remain in the Plan a minimum of 12 months. Less than 12 month participation may result in Subscriber being responsible for the Usual and Customary Fees for services received, reduced by the sum of the Subscription Dues and copayments paid.

Part IV. SUBSCRIPTION DUES AND MEMBER COPAYMENTS
A. Monthly Subscription Dues are due on the first day of the month in which services may be rendered. Annual Subscription Dues are due on the first day of the first month of the Plan year in which services may be rendered. Member Copayments (as listed in the attached Description of Benefits and Member Copayments) are payable to the Participating Dentist at the time services are rendered.
B. If Electronic Funds Transfers is not utilized for Annual Subscription Dues, payments should be mailed to: Dominion Dental Services, Inc., P.O. Box 75314, Charlotte, NC 28275-5314. Monthly Subscription Dues must be debited from either a bank or credit card account.

Part V. BENEFITS AND COVERAGE
All dental procedures listed under the attached Description of Benefits and Member Copayments will be provided if, in the opinion of the Participating Dentist, they are necessary for the patient's dental health. The fee charged will be the fee listed under Member Copayments for each procedure completed. Only the Participating Dentist shall have the right to examine and to determine the professional services to be performed pursuant to the Plan. If conflict arises regarding the quality, cost, or extent of work, the case in question will be resolved pursuant to the Appeal or Quality Assurance Procedures established by the Plan. Referrals to a Plan Specialist must be made by the Member's Participating Dentist, except in the case of orthodontics. If the Member's Participating Dentist determines, in consultation with the Plan Specialist, that the Member needs continuing care from the Plan Specialist or the Member has a condition that is life threatening, degenerative, chronic, or disabling, and requires specialized care, a standing referral shall be made in accordance with a written treatment plan developed by the Member's Participating Dentist, the Plan Specialist, and the Member. A Participating Dentist may refer a Member to a nonparticipating specialist if the Member is diagnosed with a condition or disease that requires treatment by a specialist, and Plan does not have a participating specialist with the professional training and expertise to treat the condition or disease, or the Plan cannot provide reasonable access to a Plan Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel. For purposes of calculating any amount payable under the Plan by the Member, Plan will treat services received as if services were provided by a Plan Specialist. Plan shall be responsible for payment of the specialist's charges to the extent the charges exceed the copayments specified in the Description of Benefits and Member Copayments. If during the term of this Contract none of the plan dentists can render necessary care and treatment to the Member due to circumstances not reasonably within the control of the Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the plan dentists, the then the Member may seek treatment from an independent licensed dentist of his own choosing. The Plan will pay the Member for the expenses incurred for the dental services with the following limitations: The Plan will pay the Member for services which are listed in the Description of Benefits and Member Copayments as ‘No Charge’, to the extent that such fees are reasonable and customary for dentists in the same geographic area; the Plan will also pay the Member for those services for which there is a copayment, to the extent that the reasonable and customary fees for such services exceed the copayment for such services as set forth in the Description of Benefits and Member Copayments. The enrollment may be required to give written proof of loss within ninety (90) days of treatment. The Plan agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner in any determination of the impossibility of providing services by plan dentists.

Part VI. DENTAL RECORDS
The dental records of all Members concerning services performed hereunder shall remain the property of the Participating Dentist or Plan Specialist. Information related to the number, cost, and delivery of services provided under the Plan to Members may be made available to the Plan by Participating Dentists or Plan Specialists for purposes of review, investigation, or evaluation of care.

Part VII. CHANGE IN SERVICE
Plan reserves the right to change the Subscription Dues or Member Copayments after completion of the term of the Contract. Subscription Dues will only be changed when the then-effective rates have been in effect for at least twelve (12) months. No change will be made without giving the Subscriber forty-five (45) days prior written notice.
Part VIII. EMERGENCY SERVICES
When a Member is more than 50 miles from their Participating Dentist, they may have emergency services rendered by any licensed dentist. Emergency services are defined as "palliative care of injury, toothache, or accident requiring the immediate attention of a dentist." Plan reimburses for emergency out-of-area services up to $10 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Payment shall be made: to: Dominion Dental Services, Inc., 115 South Union Street, Suite 300, Alexandria, Virginia 22314, ATTN: Accounting Dept. When a Member has a dental emergency within the service area, but is unable to arrange arrangements to receive care through their Participating Dentist, treatment must be pre-authorized by contacting Plan Member Services at (888) 518-5338.

Part IX. PROOF OF LOSS
Failure to provide proof of loss, as specified in Part V and Part VIII, within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one year from the time proof is otherwise required.

Part X. INCONTESTABILITY CLAUSE AND LEGAL ACTIONS
This Agreement may not be contested, except for nonpayment of Subscription Dues, after it has been in force for two years from its date of issue. In the absence of fraud, all statements made by a Subscriber shall be considered representations and not warranties and no statement shall be the basis for voiding coverage or denying a claim after the Contract has been in force for two years from its effective date. A statement made to effectuate insurance may not be used to void the insurance or reduce benefits under the policy unless the statement is contained in written instrument signed by the Subscriber and a copy of the statement is given to the Subscriber. No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Contract. No such action will be brought after the expiration of three years after written proof of loss is required to be furnished.

Part XI. HOW TO RECEIVE BENEFITS
In order to make an appointment, Members must contact their selected dental office. The first appointment scheduled will usually be for the purpose of taking a complete set of full mouth x-rays, an examination, developing a treatment plan, and providing an estimate of the cost of needed work. Members must pay the fees listed for each covered procedure performed on the Description of Benefits and Member Copayments. These fees are paid directly to the Participating Dentist who renders treatment. In the event the Participating General Dentist determines specialty care is necessary, the Participating General Dentist will provide a referral to a Plan Specialist (if available). The Participating Dentist may also refer the Member to a non-participating specialist as set forth in Part V.

Part XII. COMPLAINTS AND APPEALS
The following definitions apply only to this Complaints and Appeals section:

A. **Appeal** shall mean a protest filed through the Plan's internal appeal process by a Member, Member's Representative or a dentist on behalf of a Member regarding a Coverage Decision concerning the Member.

B. **Appeal Decision** shall mean a final determination by the Plan that arises from an appeal filed with the Plan under its appeal process regarding a coverage decision concerning a member.

C. **Coverage Decision** shall mean (i) an initial determination by the Plan or representative of the Plan that results in noncoverage of a dental service; (ii) a determination by a carrier that an individual is not eligible for coverage under the carrier's health benefit plan; or (iii) any determination by a carrier that results in the rescission of an individual's coverage under a health benefit plan. Coverage Decisions include nonpayment of all or any part of a claim.

D. **Member's Representative** shall mean an individual who has been authorized by the member to file an appeal or a complaint on behalf of the member.

E. **Urgent Dental Condition** shall mean a dental condition where the absence of dental attention within 72 hours would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision, or a condition that would result in: (i) placing the Member's life or health in serious jeopardy, (ii) the inability of the Member to regain maximum function, (iii) serious impairment to bodily function, (iv) serious dysfunction of a bodily organ or part, or (v) the Member remaining seriously mentally ill with symptoms that cause the Member to be a danger to self or others. In determining whether an Urgent Dental Condition exists, the Plan will apply the judgment of a prudent layperson who possesses an average knowledge of dental health.

Most Appeals can be resolved over the telephone. The Member should call the Dominion Member Services Department at (703) 518-5338 or (888) 518-5338. Appeals involving patient care should initially be brought to the attention of the Member's Participating Dentist. If the issue is not resolved to the Member's satisfaction, it may be sent in writing to the Member Services Department, Dominion Dental Services, Inc., 115 S. Union Street, Suite 300, Alexandria, Virginia 22314. The Member will receive an acknowledgement letter and Dominion's Appeal Procedures within 15 days after filing an Appeal. The Member, Member's Representative, and a dentist acting on behalf of the Member will receive a written response to the Appeal within 60 working days after the date the Appeal is filed. If an Appeal can not be satisfactorily resolved, the Member, Member's Representative or a dentist may file a complaint with the Insurance Commissioner within 4 months after Dominion's Appeal Decision at: Maryland Insurance Administration, Life and Health Complaint Unit, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202 - Phone (800) 492-6116 - Fax (410) 468-2260. The Member, Member's Representative or a dentist may file a complaint with the Maryland Insurance Administration without first filing it with Dominion if the Coverage Decision involves an Urgent Dental Condition for which care has not been rendered. The Health Advocacy Unit of Maryland's Consumer Protection Division is available to assist the Member or Member's Representative with filing an Appeal under Dominion's Appeal Procedures. The unit can also attempt to mediate a resolution to a Member's dispute. The Health Advocacy Unit is not available to represent the Member during any proceeding of the Appeal process. The Member may contact the Health Advocacy Unit at: Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, Maryland 21202 - Phone (410) 528-1840 or toll-free 1 (877) 261-8807 - Fax (410) 576-6571 - Email heau@oag.state.md.us.

Part XIII. ENTIRE CONTRACT
The Enrollment Application and this Individual Dental Policy (including any attachments thereto) constitute the entire Contract between the parties. No portion of the charter, bylaws, or other corporate documents of Dominion Dental Services, Inc. will constitute part of the Contract. No change in this Contract shall be valid until approved by an executive officer of the Plan and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Contract or to waive any of its provisions.

ATTACHMENTS
Description of Benefits and Member Copayments
Membership Identification Card
Notice of Privacy Practices

These attachments contain other terms, including important exclusions and limitations. Subscribers may request additional copies by contacting Member Services at (888) 518-5338.