

SERFF Tracking Number: DMND-127841187

State: District of Columbia

Filing Company: Avalon Insurance Company

State Tracking Number:

Company Tracking Number:

TOI: H201 Individual Health - Vision

Sub-TOI: H201.000 Health - Vision

Product Name: Avalon Individual Vision Plan Forms/Rates

Project Name/Number: /

Correspondence Summary

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Review Status	Note To Filer	Efren Tanhehco	01/30/2012	01/30/2012

SERFF Tracking Number: DMND-127841187

State: District of Columbia

Filing Company: Avalon Insurance Company

State Tracking Number:

Company Tracking Number:

TOI: H20I Individual Health - Vision

Sub-TOI: H20I.000 Health - Vision

Product Name: Avalon Individual Vision Plan Forms/Rates

Project Name/Number: /

Note To Filer

Created By:

Efren Tanhehco on 01/30/2012 09:36 AM

Last Edited By:

Efren Tanhehco

Submitted On:

01/30/2012 09:36 AM

Subject:

Review Status

Comments:

Still in progress

SERFF Tracking Number: DMND-127841187 State: District of Columbia
 Filing Company: Avalon Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
 Product Name: Avalon Individual Vision Plan Forms/Rates
 Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	11VPCOV	Outline of Coverage	Vision Plan Coverage Schedule	Initial		37.000	11VPCOV.pdf Explanation of Variability Statement Coverage Schedule.pdf
	DC 11IVCOC	Policy/Contract/Fraternal Certificate	Individual Vision Policy	Initial		36.400	Explanation of Variability Statement all documents other than Coverage Schedule (DC)- Individual.pdf DC 11IVCOC.pdf CICD-V11.pdf
	CICD-V11	Other	Change in Coverage Form	Initial			
	SGVISION11	Application/Enrollment Form	Vision Plan Enrollment Form	Initial			SGVISION11.pdf
	TCD-V11TK	Application/Enrollment Form	Dental/Vision Enrollment Form	Initial			TCD-V11TK.pdf

[Vision Plan]

Benefit Summary

	<u>Copayments</u>	<u>Frequency</u>
Exam	[\$10]	[12 months]
Lenses	[\$20]	[24 months]
Frames	[None]	[24 months]
Contact Lenses	[None]	[24 months]

Lenses Benefit Options (in-network) (in addition to lenses copayment above)

UV Coating	[\$15]
Tint	[\$15]
Scratch Resistance	[\$15]
Polycarbonate	[\$40]
Anti-Reflective	[\$45]
Standard Progressive	[\$65]
Other Add Ons	[20%] Retail Discount

Maximum Allowances¹

Preferred Provider:

Frame	[\$100]
Contact Lenses	[\$100]

[(instead of glasses)]

Non-Preferred Provider:

Exam	[\$25]
Frames	[\$40]
Single Vision Lenses	[\$20]
Bifocal Lenses	[\$30]
Trifocal Lenses	[\$40]
Contact Lenses	[\$60]

LASIK Discount

[15%] Retail Discount
[5%] Promotional Price Discount

¹ The scheduled amounts shown are the maximum allowable amount. The actual amount to be paid for any service or material will be the lesser of the scheduled amount for such service rendered and/or materials purchased, or the actual amount charged. There is no assurance that the scheduled amount will be sufficient to pay the full cost of the service rendered or the materials selected.

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

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

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

B. **Materials:**

1. Lenses: [Plan will pay for lenses on a new prescription for standard lenses once every [24 months]. The lens allowance equals two (2) lenses. If only one (1) lens is needed the allowance will be half (1/2) the lens allowance.]
2. Frames: [Plan will pay for frames once every [24 months].]
3. Contact Lenses: [Plan will pay for contact lenses once every [12 months].]

C. **Benefits:**

Participating Provider shall mean a licensed provider who has contracted to accept, as full payment, Member's copayment and the contracted payment from Plan. Plan will pay benefits if the services are rendered or materials are furnished by a Participating Provider.

Use of a Participating Provider does not guarantee that all expenses will be covered under the Policy. Participating Provider locations are identified by contacting the Plan's Member Services Department or the website.

Services and materials will be covered at the benefit levels for a Non-Participating Provider when: a) the provider rendering the service or furnishing the materials is no longer a Participating Provider; or b) the Member elects not to use the services or materials of the Participating Provider.

Non-Participating Provider shall mean a licensed provider NOT under contract with Plan. After the applicable copayment, Plan will pay the reasonable and customary charge for services and materials, up to the scheduled amount shown in this document.

Benefits will be payable the same as for a Participating Provider when: a) a Participating Provider refers the Member to a Non- Participating Provider because the Participating Provider is unable to render the necessary service or furnish the necessary materials; or b) a Non- Participating Provider is on call in the absence of the Participating Provider.

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

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

Plan Exclusions:

1. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
2. Services which are covered under Medicare, worker's compensation, employer's liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law.
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 vision procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Orthoptic or vision training and any associated supplemental testing.
8. Plano lenses.
9. Two pair of glasses, in lieu of bifocals or trifocals.
10. Medical or surgical treatment of the eyes.
11. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
12. Customization of bifocal lenses to a progressive or no-line lens.
13. Photo-chromatic lenses.
14. Sub-normal vision aids or non-prescription lenses.
15. Services rendered or materials purchased outside the U.S. or Canada, unless: a) the Member resides in the U.S. or Canada; and b) the charges are incurred while on a business or pleasure trip.
16. Charges in excess of the usual and customary charge for the service or materials.
17. Charges incurred after: a) the Policy ends; or b) the Member's coverage under the Policy ends, except as stated in the Policy.

18. Experimental or non-conventional treatment or device.
19. Spectacle lens treatments or "add-ons," except solid tints (#1 & #2), and oversize lenses.
20. High Index lenses of any material type.
21. Lost or broken materials, except when replaced at normal intervals when services are available.
22. Maryland policyholders only: Any bill, or demand for payment, for a vision service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

Underwritten by
Avalon Insurance Company
Administered and Marketed by
[Dominion Dental Services USA, Inc.]



AVALONSM
Insurance Company



[Vision Plan] Coverage Schedule

[Dominion Dental Services USA, Inc.]
[115 South Union Street]
[Suite 300]
[Alexandria • Virginia • 22314]
Toll Free [(888) 518-5338]
[DominionDental.com]
[PID 101]

Explanation of Variability Statement
Avalon Insurance Company (“Avalon”) – NAIC #12358
Form Name: Vision Plan Coverage Schedule
Form Number: 11VPCOV

The following explanations of the variable data (bracketed) pertain to the Vision Plan Coverage Schedule (Form No. 11VPCOV).

Cover page

1. Number in bottom right corner is an internal number used for plan administration. The number will vary for each unique plan design. We may or may not use this internal code but have added it for the option of including it.
2. Dominion Dental Services USA, Inc. is bracketed so that we have flexibility if we change the name, or create a DBA (i.e., Dominion Vision Services), for the marketer and administrator of the vision products.
3. Dominion Dental Services USA, Inc. logo is bracketed so that we have flexibility if we change the name, or create a DBA (i.e., Dominion Vision Services), for the marketer and administrator of the vision products.
4. Dominion Dental Services USA, Inc.’s (“Dominion”) office address is bracketed so filing is not required if address changes.
5. “Vision Plan” is bracketed so that we have some flexibility concerning the brand name of the product/plan. For example, we may use names such as Precision Plan, Focus Plan and Plus Plan and may also use a numeric extension.

Shaded bordered area titled “Vision Plan”

1. The plan name “Vision Plan” will vary depending on the benefit coverage (amount paid by Dominion) for each benefit(s) for the particular plan.
2. The benefit summary copayments, frequency, allowances and discounts will vary depending on the particular vision plan selected. If a benefit is not offered for a particular plan, “N/A” will be displayed. Approximately 16 vision plan options will be offered.

Section listing the Services:

1. Vision examinations Plan coverage frequency “[12 months]” will vary depending on which vision plan is selected.

Section listing the Materials:

1. Items: Lenses, Frames and Contact Lenses will vary depending on the particular vision plan selected. If a benefit is not offered for a particular plan, “N/A” will be displayed. Approximately 16 vision plan options will be offered.
2. Items: Lenses, Frames and Contact Lenses Plan coverage frequency “[24 months]” will vary depending on which vision plan is selected.

Explanation of Variability Statement
Avalon Insurance Company (“Avalon”) – NAIC #12358

This includes all forms except 11VPCOV (Vision Coverage Schedule). Please refer to separate Explanation of Variability Statement for this form.

<u>Form</u>	<u>Form #</u>	<u>Form Location</u>	<u>Bracketed Language</u>	<u>Explanation</u>
Individual Vision Policy	DC 11VICOC	Cover page	[Dominion Dental Services USA, Inc.]	“Dominion Dental Services USA, Inc.” is bracketed so that we have flexibility if we change the name, or create a DBA (i.e., Dominion Vision Services), for the marketer and administrator of the vision products.
Individual Vision Policy	DC 11VICOC	Cover page	[Dominion Dental Services USA, Inc. logo]	“Dominion Dental Services USA, Inc.” logo is bracketed so that we have flexibility if we change the name, or create a DBA (i.e., Dominion Vision Services), for the marketer and administrator of the vision products.
Individual Vision Policy	DC 11VICOC	Cover page	[115 S. Union Street, Suite 300, Alexandria, Virginia 22314]	Any address may be inserted. Allows us to change office location.
Individual Vision Policy	DC 11VICOC	Cover page	[(703) 518-5000], [(888) 518-5338]	Any phone number may be inserted. Allows us to change phone numbers.
Individual Vision Policy	DC 11VICOC	Intro. – 2 nd paragraph	[Dominion Dental Services USA, Inc.]	“Dominion Dental Services USA, Inc.” is bracketed so that we have flexibility if we change the name, or create a DBA (i.e., Dominion Vision Services), for the marketer and administrator of the vision products.

Form	Form #	Form Location	Bracketed Language	Explanation
Individual Vision Policy	DC 11VICOC	Intro. – 2 nd paragraph	[115 S. Union Street, Suite 300, Alexandria, Virginia 22314]	Any address may be inserted. Allows us to change office location.
Individual Vision Policy	DC 11VICOC	Intro. – 2 nd paragraph	[(703) 518-5000]	Any phone number may be inserted. Allows us to change phone numbers.
Individual Vision Policy	DC 11VICOC	Part I-A. Dependent	[26 th]	Dependent age limit max is 26 years of age. This allows flexibility in the event the age limit requested is less than 26.
Individual Vision Policy	DC 11VICOC	Part III-B. TERMINATION OR CANCELLATION	[26]	Dependent age limit max is 26 years of age. This allows flexibility in the event the age limit requested is less than 26.
Individual Vision Policy	DC 11VICOC	Part IV-B. PREMIUMS	[Dominion Dental Services USA, Inc.]	“Dominion Dental Services USA, Inc.” is bracketed so that we have flexibility if we change the name, or create a DBA (i.e., Dominion Vision Services), for the marketer and administrator of the vision products.
Individual Vision Policy	DC 11VICOC	Part IV-B. PREMIUMS	[P.O. Box 75314, Charlotte, NC 28275-0314]	Any address may be used. Allows us to change the address for premium remittance.
Individual Vision Policy	DC 11VICOC	Part X. COMPLAINTS AND GRIEVANCES	[Dominion Dental Services USA, Inc.]	“Dominion Dental Services USA, Inc.” is bracketed so that we have flexibility if we change the name, or create a DBA (i.e., Dominion Vision Services), for the marketer and administrator of the vision products.

Form	Form #	Form Location	Bracketed Language	Explanation
Individual Vision Policy	DC 11VICOC	Part X. COMPLAINTS AND GRIEVANCES	[115 S. Union Street, Suite 300, Alexandria, Virginia 22314]	Any address may be inserted. This allows us to change office location or address for sending written complaints.
Individual Vision Policy	DC 11VICOC	Part X. COMPLAINTS AND GRIEVANCES	[(800) 672-7723]	Any phone number may be inserted. Allows us to change phone numbers.
Individual Vision Policy	DC 11VICOC	Attachments	[(888) 518-5338]	Any phone number may be inserted. Allows us to change phone numbers.

Avalon Insurance Company (hereinafter referred to as "Plan") certifies that the Subscriber and eligible enrolled Dependent(s), if any, are covered under and subject to all the provisions, definitions, limitations and conditions of this Individual Vision Policy for the Benefits approved herein, and is eligible for Benefits stated in the attachments hereto (Coverage Schedule) 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 USA, Inc.], [115 South Union Street, Suite 300, Alexandria, Virginia 22314]. The telephone number is [(703) 518-5000].

Part I. DEFINITIONS

- A. **Benefits** shall mean a service or material listed and the amount payable by the Plan, as set forth in the Coverage Schedule.
- B. **Calendar Year** shall mean January 1st through December 31st.
- C. **Copayment** shall mean the dollar amount a Member is required to pay, if any, when a Service is rendered or Materials purchased.
- D. **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 may include a Domestic Partner of Subscriber and/or children of a Domestic Partner. 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 such adoptive or parental placement. However, application for coverage must be submitted within 31 days from date of eligibility, along with proof that the adoption is pending. If a newborn infant 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. 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. Proof of such incapacity and dependency shall be 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; however, not more than annually after the two-year period following the child's attainment of limiting age.

- E. **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. In order to obtain coverage for a Domestic Partner, Subscriber must provide a registration of Domestic Partnership as required by DC ST § 32-702.
- F. **Eligible Expenses** shall mean covered vision care expenses.
- G. **Materials** shall mean lenses, frames and contact lenses.
- H. **Member** shall mean any individual Subscriber or eligible family Dependent entitled to receive services by reason of the Contract.
- I. **Necessary** shall mean that Services rendered or Materials furnished are necessary and appropriate based on general accepted current practice. A service or supply will not be considered Necessary if: a) provided only as a convenience to the Member or provider; or b) not appropriate for the diagnosis or symptoms.
- J. **Premiums** shall mean amounts payable on a regular prepayment basis by or for the Subscriber to the Plan.
- K. **Subscriber** shall mean an individual in good standing who has paid the Premiums for services of the Plan prior to the period of eligibility, including payments for Dependents as hereinafter defined. In the event of the Subscriber's death, the spouse or Domestic Partner of the Subscriber, if covered under the policy, shall become the Subscriber.
- L. **Reasonable and Customary** shall mean the usual, customary and regular charges for the area where such expenses are incurred.

Part II. EFFECTIVE DATE OF BENEFITS

- A. All persons, who have enrolled in the Plan and paid the appropriate Premiums on or before the 17th day of the month, shall be eligible for Benefits commencing on the 1st day of the following month or on any date mutually agreed upon by Plan and Subscriber.
- B. All persons who have enrolled in the Plan and paid the appropriate Premiums 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 or on any date mutually agreed upon by Plan and Subscriber.
- C. All Subscribers and enrolled Dependents become eligible for services on the effective date 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 Premiums 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. If notice of intention to terminate the Contract is received during the grace period, the Plan may collect Premiums for the period beginning the first day of the grace period until the date on which notice is received or the date of termination stated in the notice, whichever is later. The Contract shall remain in full force and effect during the grace period.
- B. **CANCELLATION BY THE SUBSCRIBER:** Upon receipt by Plan of written notice by Subscriber delivered or mailed to the Plan effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, the Plan shall return promptly the unearned Premiums paid, computed on a pro rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
- C. Upon the date of Dependents attaining the age of [26] years or marriage prior to that date (Subject to Part I-D).

Part IV. PREMIUMS

- A. Monthly Premiums are payable on or before the 17th day of the month preceding the month in which services may be rendered. Annual Premiums are payable on or before the 17th day of the month preceding the first month of the Plan year in which services may be rendered. Member Copayments (as listed in the attached Coverage Schedule) are payable to the Participating Provider at the time services are rendered.
- B. Premiums must be received in the administrative office of the Plan no later than the 17th day of the month before eligibility is desired. If Electronic Funds Transfers is not utilized, payments should be mailed to: [Dominion Dental Services USA, Inc.], [P.O. Box 75314, Charlotte, NC 28275-5314]. Monthly Premiums must be debited from either a bank or credit card account.

Part V. REINSTATEMENT

If any renewal Premiums are not received by the due date, subject to the grace period provision in Part III-A, and if payment is received within 60 days from the last date of coverage, the policy will be reinstated upon receipt of the Premiums due without the submission of a new enrollment form or approval by the Plan. If payment is not received within 60 days, Subscriber will be required to wait 12 months from the last date of coverage to re-enroll in the Plan.

Part VI. COORDINATION OF BENEFITS

All covered procedures are listed under the attached Coverage Schedule and subject to coordination.

The following definitions apply only to this Coordination of Benefits section:

- A. **Plan** shall mean coverage providing hospital, medical or vision Benefits or services by: i) group or blanket insurance coverage except school accident coverage; ii) group Blue Cross and Blue Shield, group practice or other pre-payment coverage on a group basis; or iii) labor-management trusted plans, union welfare plans, employer organization plans or employee benefit plans. Plan will be construed separately for a policy, contract, or other arrangement for Benefits or services that reserves the right to take the Benefits or services of their Plans into consideration in determining its Benefits, or separately for that portion which does not reserve the right.
- B. **Eligible Expenses** shall mean any necessary, reasonable and customary item of expense all or part of which is covered under one of the Plans. When a Plan provides Benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Eligible Expense and a benefit paid.
- C. **Claim Period** shall mean a Calendar Year or portion of a Calendar Year for a claim on a Member covered under this Plan.

If Member is also covered under one or more other Plans, the Benefits under this Plan will be coordinated with Benefits payable under all other Plans. The coordination will apply in determining the Benefits payable for any Claim Period if the sum of: i) the Benefits that would be payable under this Plan in absence of the coordination; and ii) the Benefits that would be payable under all other Plans without provisions for coordination in those Plans, would exceed such Benefits.

Except as provided in the following paragraph, when Coordination of Benefits applied to the Benefits payable for any Claim Period, the Benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced Benefits and all the Benefits payable for those Eligible Expenses under all other Plans will not exceed the total of those Eligible Expenses. Benefits payable under all other Plans include the Benefits that would have been payable had a claim been properly made for them.

The rules establishing the order of benefit determination are:

1. The Benefits of a plan covering a person for whom claim is made other than as a dependent will be determined before the Benefits of a plan covering such person as a dependent.

2. Except as stated in (3) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":
 - a. the Benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - b. if both parents have the same birthday, the Benefits of the Plan covering the parent longer are determined before Benefits of the Plan covering the other parent for the shorter period of time. However, if the other Plan does not have the rule described in (a) above, but instead uses a different method, and if, as a result, the Plans do not agree on the order of Benefits, the rule in the other Plan will determine the order of Benefits.
3. If two or more Plans cover a person as a dependent child of divorced or separated parents, Benefits for such child are determined in this order:
 - a. first, the Plan of the parent with custody of the child;
 - b. then, the Plan of the spouse of the parent with custody of the child; and
 - c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the Plan of such parent has actual knowledge of those terms, the Benefits of that Plan are determined first. This does not apply with respect to any Claim Period or Plan Year during which any Benefits are actually paid or provided before the entity has that actual knowledge.
4. The Benefits of a Plan covering a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as the employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Benefits, this rule (4) is ignored.
5. If none of the above rules determines the order of Benefits, the Benefits of a Plan which has covered the person for whom claim is made for the longer period of time will be determined before the Benefits of a Plan covering the person the shorter period of time.

If this Plan is responsible for secondary coverage for Eligible Expenses, this Plan will not deny coverage or payment of the amount it owes as secondary payer solely on the basis of the

(Go to next column labeled 7)

Underwritten by
Avalon Insurance Company
Administered and Marketed by
[Dominion Dental Services USA, Inc.]



AVALONSM
Insurance Company



Individual Vision Policy

Limited Benefit
Please Read Carefully

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This policy was issued based on the information entered in your application. If you know of any misstatement in your application, you should advise the Plan immediately regarding the incorrect or omitted information; otherwise, your policy may not be a valid contract.

THIS POLICY IS GUARANTEED RENEWABLE subject to timely payment of premiums. Premiums are subject to change on a uniform basis for all subscribers covered under this policy form.

RIGHT TO RETURN POLICY WITHIN TEN DAYS: If for any reason you are not satisfied with your policy, you may return this policy to the Plan within 10 days of the date you received it and the premium you paid will be promptly refunded.

[Dominion Dental Services USA, Inc.]
[115 S. Union Street]
[Suite 300]
[Alexandria • Virginia • 22314]
[(703) 518-5338]
[Toll Free (888) 518-5338]

failure of another contract, which is responsible as the primary payer, to pay for such Eligible Expenses. This Plan will not be required to pay the obligations of the primary payer.

For the purposes of administering the above provisions of this Contract or any similar provisions of other Plans, this Plan may, without consent or notice to any person, release to or obtain from any other insurance company, organizations or person, any information concerning any individual which is considered necessary. Any person claiming Benefit will furnish the Plan with any information necessary.

Whenever payments which should have been made under this Contract in accordance with the above provisions have been made under any other Plans, this Plan has the right to pay any organizations making these payments any amount this Plan determines to be due. Amounts paid in this manner will be considered to be Benefits paid under this Contract and, to the extent of these payments, Plan will be fully discharged from liability under this Contract. Whenever payments have been made by this Plan, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, this Plan will have the right to recover the excess from one or more of the following: (i) other insurance companies; (ii) other organizations; or (iii) persons to or for whom payments were made. The Department of Medical Assistance Services shall be the payor of last resort for services provided under this Contract.

Part VII. VISION RECORDS

The vision records of all Members concerning services performed hereunder shall remain the property of the treating provider. Information related to these records may be made available to the Plan by providers for purposes of review, investigation, or evaluation of care.

Part VIII. CHANGE IN SERVICE

Plan reserves the right to change the Premiums or Benefits after completion of the term of the Contract. Premiums will be changed only when the then-effective rates have been in effect for at least twelve (12) months. No change will be made without giving the Subscriber sixty (60) days prior written notice.

Part IX. CLAIMS

PAYMENT OF CLAIMS: If Plan provides coverage of a Member as a Dependent of a parent who has legal responsibility for the Dependent's vision care, and such parent does not have custody of the Dependent, the Plan may, upon request of the custodial parent, make the payments directly to the treating provider. Any payments so made will release Plan from all further liability to the Member to the extent of the payments made. Benefits for other losses are paid to the Member. However, the Plan has the right to pay all or part of the Benefits due to the treating provider. This is true whether or not

the Member is alive. If the Member has died and the Plan does not pay accrued Benefits to the treating provider, Benefits will be paid to the Member's estate.

CLAIM FORMS/NOTICE OF CLAIM: If Plan receives a notice of claim it will provide claim forms for filing proof of loss. Instructions for submitting notice of claim to Plan can be found on the Membership Identification Card.

PROOF OF LOSS: Plan must receive written proof of loss within 180 days of treatment. Failure to provide proof of loss 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. Instructions for submitting proof of loss to Plan can be found on the Membership Identification Card.

TIME OF PAYMENT OF CLAIM: Benefits payable under this Contract for any loss will be paid immediately or within 30 days after receipt of proof of loss. If Plan fails to pay claim within the time required by state regulations, it will pay interest from the date on which payment is required to the date the claim is paid.

INCONTESTABILITY CLAUSE: In the absence of fraud, all statements made by a Subscriber shall be considered representations and not warranties. 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, unless the statement was material to the risk and was contained in a written application. No written statement made by any Member shall be used in any contest unless a copy of the statement is furnished to the Member or the Member's beneficiary or personal representative.

LEGAL ACTIONS: 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 X. COMPLAINTS AND GRIEVANCES

IMPORTANT INFORMATION REGARDING YOUR INSURANCE Complaints involving patient care should initially be brought to the attention of the Participating Provider. If the issue is not resolved to the Member's satisfaction, or if the Member has grievances or questions regarding issues other than patient care, they may contact Member Services at [Dominion Dental Services USA, Inc.] c/o NVA, Attn: Member Complaints, [1200 Route 46 West, Clifton, NJ 07013], [(800) 672-7723]. It is recommended that all Members familiarize themselves with the Complaint Procedures, and make use of it before taking any other action. NVA will respond to a Member's grievance, complaint or appeal within thirty (30) days

of the date it is received. An appeal of a claim decision must be received by NVA within 180 days of receipt of the claim decision.

If Member is dissatisfied with the resolution reached by NVA regarding medical necessity, Member may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following: FOR MEDICAL NECESSITY CASES: District of Columbia Department of Health Care Finance, Office of the Health Care Ombudsman and Bill of Rights, [825 North Capital Street, N.E., 6th Floor, Washington, D.C. 20002], [(877) 685-6391], Fax: [(202) 478-1397].

If Member is dissatisfied with the resolution reached by NVA regarding a non-medical necessity case, Member may contact the Commission at the following: [Gennet Purcell], Commissioner, Department of Insurance, Securities and Banking, [810 First St. N.E., 7th Floor, Washington, D.C. 20002], [(202) 727-8000], Fax: [(202) 354-1085].

Part XI. CONFORMITY WITH STATE STATUTES

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date hereby is amended to conform to the minimum requirements of such statutes.

Part XII. ENTIRE CONTRACT

The Enrollment Application and this Individual Vision Policy (including any attachments thereto) constitute the entire Contract. No portion of the charter, bylaws, or other corporate documents of Avalon Insurance Company 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.

Part XIII. DISTRICT OF COLUMBIA LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION ACT OF 1992

Summary of General Purposes and Current Limitations of Coverage

Residents of the District of Columbia who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty

Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted on the other side of this page.

Disclaimer

The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.

The District of Columbia Life and Health Guaranty Association or the District of Columbia Insurance Commissioner will respond to any question, you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer. Policyholders with additional questions may contact:

[Ms. Gennet Purcell], Commissioner, District of Columbia Department of Insurance, Securities and Banking, [810 First Street, N.E., Suite 701, Washington, D.C. 20002], [(202) 727-8000] or [Mr. Robert M. Willis], [Executive Director], District of Columbia Department of Insurance, Securities and Banking, [810 First Street, N.E., Suite 701, Washington, D.C. 20002], [(202) 434-8771], Fax: [(202) 347-2990].

The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance guaranty Association Act of 1992. This page contains a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

Coverage

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside of that state of incorporation);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity Benefits to its employees or members to the extent the plan is self-funded or uninsured;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Limits on amount of Coverage

The Act also limits the amount the Guaranty Association is obligated to pay. The Benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- *the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or*
- *with respect to any one life, regardless of the number of policies, contracts, or certificates:*
 - *\$300,000 in life insurance death Benefits but not more than \$100,000 in net cash surrender or net cash withdrawal values for life insurance; or*
 - *\$100,000 in health insurance Benefits, including net cash surrender or net cash withdrawal values; or*
 - *\$300,000 in the present value of annuity Benefits, including net cash surrender or net cash withdrawal values.*

Finally, in no event is the Guaranty Association liable for more than \$300,000 with respect to any one individual.

ATTACHMENTS

Coverage Schedule
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].

CHANGE IN COVERAGE FORM

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Change Plans: | <input type="checkbox"/> Address/Name Change | <input checked="" type="checkbox"/> Add Dependents |
| <input checked="" type="checkbox"/> [Select Plan ¹] | <input type="checkbox"/> Terminate Subscriber | <input type="checkbox"/> Delete Dependents |
| <input type="checkbox"/> [Access PPO Plan ¹] | <input type="checkbox"/> Split Dental Centers | <input type="checkbox"/> Change Dental Office |
| <input type="checkbox"/> [Avalon Vision ²] | | ([SELECT PLAN] ONLY) |

Changes to Subscriber Information						
Last Name [Smith]		First Name [Mary]			M.I. [J]	
Plan Number [54321]		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		Birthdate (MM/DD/YY) [01/01/01]		
Home Address [123 West Avenue]				Home Phone [703-123-3456]		
City [Alexandria]		State [VA]	ZIP [22314]	Work Phone [703-518-5000]		
Changes to Selected Dental Office ([SELECT PLAN] ONLY)						
Dental Office Code [3456]		Dental Office Name [Smile Now Dental]				
Changes to Spouse Information						
	Sex (M/F)	Last Name (if different)	First Name	M.I.	Date of Birth	[SELECT PLAN] ONLY: Dental Office (if different)
<input type="checkbox"/> Add <input checked="" type="checkbox"/> Delete	[M]	[Smith]	[Michael]	[D]	[02/02/02]	[Smile Now Dental]
Changes to Dependent Information						
	Sex (M/F)	Last Name (if different)	First Name	M.I.	Date of Birth	[SELECT PLAN] ONLY: Dental Office (if different)
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete	[M]	[Smith]	[Joe]	[M]	[03/03/03]	[Smile Now Dental]
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete	[F]	[Smith]	[Jane]	[J]	[04/04/04]	[Smile Now Dental]
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete	[F]	[Smith]	[Erin]	[B]	[05/05/05]	[Smile Now Dental]
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete	[M]	[Smith]	[Ryan]	[R]	[06/06/06]	[Smile Now Dental]
Authorization						
Subscriber's Signature _____					Date _____	
To Be Completed By Benefits Administrator						
Group Number [56789]		Group Name [Offsite Construction]			Effective Date of Change	[11] / [01] / [11] Mo. Day Yr.

¹ The dental plans are underwritten by Dominion Dental Services, Inc.

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

[Dominion Dental Services USA, Inc.] • [115 South Union Street, Suite 300] • [Alexandria, VA 22314]
 [(703) 518-5338] • Toll Free [(888) 518-5338] • Fax [(703) 518-0627]

SELECT ONE: I choose [the Avalon vision¹ plan 1]
 I choose [the Avalon vision¹ plan 2]
 I choose [the Avalon vision¹ plan 3]

Enrollment Information

Last Name [Smith]		First Name [Mary]		M.I. [J]
Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		Birthdate (MM/DD/YY) [01/01/01]		
Home Address [123 West Avenue]			Home Phone [703-123-3456]	
City [Alexandria]	State [VA]	ZIP [22314]	Work Phone [703-518-5000]	
Email Address [msmith528@email.com]		Does this plan replace other dental coverage? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse [Smith]	[Michael]	[D]	[M]	[02/02/02]
Child [Smith]	[Joe]	[M]	[M]	[03/03/03]
Child [Smith]	[Jane]	[J]	[F]	[04/04/04]
Child [Smith]	[Erin]	[B]	[F]	[05/05/05]
Child [Smith]	[Ryan]	[R]	[M]	[06/06/06]
Child [Smith]	[Bob]	[A]	[M]	[07/07/07]
Child [Smith]	[Ali]	[K]	[F]	[08/08/08]

I understand and agree that my signature on this enrollment form serves as my legal commitment to the plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of vision services. Information will be released to Avalon Insurance Company for the purposes of quality assurance and/or utilization review. 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 _____

Administrative Use Only

Group Name [Offsite Construction]	Group # [56789]	Coverage Eff. Date [11/01/11]	Plan # [54321]	Agent/Broker # [1234]
--------------------------------------	--------------------	----------------------------------	-------------------	--------------------------

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

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

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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. Virginia - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Dental/Vision Enrollment Card

DENTAL I choose [the Dominion Discount Program¹]
SELECT ONE: I choose [the Dominion Select Plan²]
 I choose [the Dominion Access PPO²]

VISION I choose [the Avalon vision³ plan 1]
SELECT ONE: I choose [the Avalon vision³ plan 2]]

Enrollment Information

Last Name [Smith]		First Name [Mary]		M.I. [J]
Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		Birthdate (MM/DD/YY) [01/01/01]		
Home Address [123 West Avenue]			Home Phone [703-123-3456]	
City [Alexandria]	State [VA]	ZIP [22314]	Work Phone [703-518-5000]	
Email Address [msmith528@email.com]				
Does this plan replace other dental coverage? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				

List All Your Eligible Dependents Below

Last Name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse [Smith]	[Michael]	[D]	[M]	[02/02/02]
Child [Smith]	[Joe]	[M]	[M]	[03/03/03]
Child [Smith]	[Jane]	[J]	[F]	[04/04/04]
Child [Smith]	[Erin]	[B]	[F]	[05/05/05]
Child [Smith]	[Ryan]	[R]	[M]	[06/06/06]
Child [Smith]	[Bob]	[A]	[M]	[07/07/07]
Child [Smith]	[Ali]	[K]	[F]	[08/08/08]

[SELECT PLAN] Provider Selection	Dental Office Name & Code # (As Indicated on Your Dentist Directory) [Smile Now Dental] [3456]
--	---

If I am enrolling in the [Select Plan] and I am voluntarily paying 100% of the cost of this plan, without employer contribution, 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. By my selection(s) above, I understand and agree that my signature on this enrollment form serves as my legal commitment to the plan(s) and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by providers of dental and/or vision services. Information will be released to Dominion Dental Services, Inc., if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, for the purposes of quality assurance and/or utilization review. 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 # [1234]	Group # [56789]	Group Name [Offsite Construction]	Coverage Eff. Date [11/01/11]
--------------------------	--------------------	--------------------------------------	----------------------------------

[Dominion Dental Services USA, Inc.], [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. The discount program is marketed and administered by Dominion Dental Services USA, Inc.

² The dental plans are underwritten by Dominion Dental Services, Inc.

³ The vision plans are underwritten by Avalon Insurance Company and administered by [Dominion Dental Services USA, Inc.]

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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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. Virginia - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TCD-V11TK

SERFF Tracking Number: DMND-127841187

State: District of Columbia

Filing Company: Avalon Insurance Company

State Tracking Number:

Company Tracking Number:

TOI: H201 Individual Health - Vision

Sub-TOI: H201.000 Health - Vision

Product Name: Avalon Individual Vision Plan Forms/Rates

Project Name/Number: /

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Actuarial Justification

Comments:

Attachment:

Avalon Insurance Company Actuarial Memorandum - DC.pdf

Item Status:

Status

Date:

Satisfied - Item: Transmittal Letter

Comments:

Attachment:

Transmittal Letter-Individual.pdf

EXHIBIT I

Avalon Insurance Company VISION INSURANCE POLICY ACTUARIAL MEMORANDUM

Policy Form Numbers

Group: DC 11GVSC and 11GVSCa1

Individual: DC 11IVCOC

Scope and Purpose

The purpose of this actuarial memorandum is to describe the benefits and assumptions for the attached vision insurance policy and to certify that this product is in compliance with applicable laws and regulations of the state. This memorandum is not intended to be used for any other purpose.

Description of Benefits

This Policy has an initial contract period of 12 or 24 months. It is designed to provide vision insurance benefits to individuals or employees of groups and their dependents through a Preferred Provider Organization (PPO), defined as follows:

There is a network panel of preferred providers. However, the insured person can still receive benefits under this Policy for vision services from any provider, network or non-network. The difference being that network providers have agreed to accept the network reimbursement schedule as payment in full, while non-network providers are reimbursed from a schedule of maximum allowable amounts. Benefits include reimbursement of expenses incurred for all covered vision procedures and equipment, subject to any plan copays, coinsurance, and maximum allowance limits. In addition, some procedures may have certain frequency limits as described in the benefits summary of the Certificate of Coverage or Individual Vision Policy.

The premiums may be paid by the individual, the employer, the employee, or a combination of both.

Renewability Clause

A Policy with a 12-month contract period is renewable annually. A Policy with a 24-month contract period is renewable biennially.

Marketing Method

This Policy is intended to be distributed primarily to employer type groups through independent agents and brokers. It may also be offered to individuals or members of association groups.

Underwriting

There is no individual underwriting of this Policy. There is no pre-existing conditions exclusion. Premium rates vary by plan design, effective date, employer contribution percentage, and whether the Policy is sold through an employer group or to individuals.

Trend

Current annual trend is assumed to be 3%. This factor includes 2% for annual provider price increases and 1% for provider cost shifting, copay leveraging and utilization increases.

Morbidity

The utilization, unit cost, and demographic assumptions used in developing premium rates are based on vision insurance industry data and experience of similar programs and coverages.

Claim Liability and Reserves

No policy reserves are required for this Policy. However, an incurred but not reported claim reserve will be held for this form. This reserve will be estimated based on standard actuarial methods.

Expenses and Profit

The expense assumptions are based on the Company's actual expected costs. The risk charge is sufficient to meet the Company's Return on Investment target, based on the level of required risk based capital.

Anticipated Loss Ratio

The anticipated loss ratio for this Policy will be 60% or greater in all durations.

Proposed Effective Date

It is requested that this Policy become effective immediately upon approval by the Department of Insurance.

Actuarial Certification

I, Mark Spitler, am an Associate of the Society of Actuaries, and a Member of the American Academy of Actuaries. I certify that to the best of my knowledge and judgment, this filing is in compliance with the applicable laws of this State and with the rules of the Department of Insurance, and complies with Actuarial Standards of Practice No. 8, "Regulatory Filings for Rates and Financial Projections for Health Plans", as adopted by the Actuarial Standards Board, December 2005. The premiums are neither excessive, inadequate, nor unfairly discriminatory; and the benefits provided are reasonable in relation to the premiums.



Mark Spitler, ASA, MAAA
Director, Actuarial Services
Capital BlueCross
717-541-6613

November 16, 2011

EXHIBIT II

RATING METHODOLOGY

Rating begins with starting cost and utilization. The attached starting cost and utilization assumptions were developed using data from a large population that remained relatively stable over a 3-year period. Cost and utilization data were extracted by procedure code. Cost is represented as average cost per service; utilization is shown per 1000 members per year. Separate in-network and out-of-network cost and utilization are used in the rating methodology.

Starting cost and utilization are then adjusted based on the selected plan designs.

Utilization is adjusted based on the chosen benefit period (12 months or 24 months), copay, and the maximum allowance levels. Shorter benefit periods, lower copays, and higher maximums will increase utilization; a longer benefit period, higher copays, and lower maximums decrease utilization.

Starting cost is adjusted based on copays, coinsurance, and maximums. Final cost per service is calculated as the minimum of the max for that service category and the starting cost, minus the copay, and multiplied by the coinsurance. For example: assume that, for exams, the starting cost is \$38 per service subject to a \$50 max and a \$10 copay. Then the final cost would be calculated as the minimum of \$38 and \$50 minus the \$10 copay, which equals \$28 per service.

The final cost and utilization are multiplied together and divided by 12,000 to determine the per member per month (PMPM) cost for each service type. The sum of the PMPM cost per service across all services is then trended from the midpoint of the experience period to the midpoint of the contract period; this is the estimated claim PMPM amount for the desired contract period.

This claim PMPM is then adjusted based on the desired low vision aid benefits (see table g for a more detailed description). The claim PMPM is also adjusted based on the employee contribution amount. A plan where the employer contributes 50% or more to the employee premium or where the employer contributes 25% or more towards all tiers is considered to be non-voluntary. Voluntary group vision plans are subject to an additional rating factor (table h). The last adjustment to the claim PMPM is based on how the product is sold. Policies sold to individuals (not through an employer group or association) are subject to an additional rating factor (table i).

Finally, retention is added to the claim PMPM to determine the PMPM premium. The PMPM premium is converted to a per contract per month (PCPM) premium by multiplying the PMPM premium by the number of members and dividing by the number of contracts. The PCPM premium can then be tiered across whatever tier structure is desired.

EXHIBIT III
CONFIDENTIAL AND PROPRIETARY
TABLES

a.) In-network starting cost and utilization

Grouping	Procedure Code	Category	Utilization per 1000	Starting Cost
Exam	92002	Exam	18.5916	37.07
Exam	92004	Exam	68.9251	37.49
Exam	92012	Exam	20.4055	38.00
Exam	92014	Exam	185.2363	37.45
Exam	92015	Exam	16.7778	38.00
Exam	99204	Exam	0.2267	38.00
Exam	99213	Exam	0.4535	44.00
Exam	99214	Exam	0.9069	38.00
Exam	S0620	Exam	27.6607	37.54
Exam	S0621	Exam	98.1730	37.05
Contact Lens Eval/Fitting	92310	Contact Lens Eval/Fitting	155.5350	26.49
Frame	V2020	Frame	204.5081	23.03
Frame	V2025	Frame	3.8544	9.88
Eyeglass Lenses	V2100	Eyeglass Lenses - Single Vision	73.2329	33.97
Eyeglass Lenses	V2101	Eyeglass Lenses - Single Vision	2.2673	24.40
Eyeglass Lenses	V2102	Eyeglass Lenses - Single Vision	1.3604	36.00
Eyeglass Lenses	V2103	Eyeglass Lenses - Single Vision	41.0377	31.84
Eyeglass Lenses	V2104	Eyeglass Lenses - Single Vision	1.3604	34.00
Eyeglass Lenses	V2105	Eyeglass Lenses - Single Vision	0.2267	29.00
Eyeglass Lenses	V2106	Eyeglass Lenses - Single Vision	0.2267	36.00
Eyeglass Lenses	V2107	Eyeglass Lenses - Single Vision	3.4009	24.60
Eyeglass Lenses	V2108	Eyeglass Lenses - Single Vision	0.2267	36.00
Eyeglass Lenses	V2110	Eyeglass Lenses - Single Vision	0.2267	36.00
Eyeglass Lenses	V2111	Eyeglass Lenses - Single Vision	2.4940	26.64
Eyeglass Lenses	V2200	Eyeglass Lenses - Bifocal	14.0571	47.84
Eyeglass Lenses	V2201	Eyeglass Lenses - Bifocal	0.2267	48.00
Eyeglass Lenses	V2203	Eyeglass Lenses - Bifocal	5.6682	46.92
Eyeglass Lenses	V2204	Eyeglass Lenses - Bifocal	0.2267	48.00

Eyeglass Lenses	V2205	Eyeglass Lenses - Bifocal	0.2267	48.00
Eyeglass Lenses	V2207	Eyeglass Lenses - Bifocal	0.4535	48.00
Eyeglass Lenses	V2212	Eyeglass Lenses - Bifocal	0.2267	48.00
Eyeglass Lenses	V2300	Eyeglass Lenses - Trifocal	63.2569	54.68
Eyeglass Lenses	V2301	Eyeglass Lenses - Trifocal	0.6802	58.00
Eyeglass Lenses	V2303	Eyeglass Lenses - Trifocal	12.2433	55.85
Eyeglass Lenses	V2311	Eyeglass Lenses - Trifocal	0.2267	58.00
Eyeglass Lenses	V2312	Eyeglass Lenses - Trifocal	2.2673	58.00
Eyeglass Lenses	V2313	Eyeglass Lenses - Trifocal	0.2267	58.00
Eyeglass Lenses	V2115	Eyeglass Lenses - Lenticular	0.2267	64.00
Eyeglass Lenses	V2784	Eyeglass Lenses - Specialty	62.3500	72.00
Contact Lenses	S0500	Contact Lenses	21.3124	49.60
Contact Lenses	V2500	Contact Lenses	55.7749	54.77
Contact Lenses	V2501	Contact Lenses	0.2267	48.00
Contact Lenses	V2510	Contact Lenses	1.5871	48.00
Contact Lenses	V2513	Contact Lenses	0.2267	48.00
Contact Lenses	V2520	Contact Lenses	14.5106	45.88
Contact Lenses	V2521	Contact Lenses	4.0811	48.08
Contact Lenses	V2522	Contact Lenses	0.6802	48.00
Contact Lenses	V2523	Contact Lenses	8.6156	44.59
Contact Lenses	V2599	Contact Lenses	1.3604	41.38
Lens Option	V2750	Lens Option - Anti-reflective	43.9851	40.00
Lens Option	V2781	Lens Option - Progressive	76.1804	50.00
Lens Option	V2760	Lens Option - Scratch Resistant	34.6893	10.00
Lens Option	V2715	Lens Option - Tint	1.8138	10.00
Lens Option	V2740	Lens Option - Tint	0.2267	10.00
Lens Option	V2744	Lens Option - Tint	31.7418	10.00
Lens Option	V2745	Lens Option - Tint	1.5871	10.00
Lens Option	V2762	Lens Option - Tint	1.1336	10.00
Lens Option	V2782	Lens Option - Tint	31.5151	10.00
Lens Option	V2783	Lens Option - Tint	7.9355	10.00
Lens Option	V2799	Lens Option - Tint	23.5796	10.00
Lens Option	V2755	Lens Option - UV	3.4009	12.00

Value Added Benefits	S0508	Value Added Benefits - Safety Glasses	0.2267	58.00
----------------------	-------	---------------------------------------	--------	-------

b.) Out-of-network starting cost and utilization

Grouping	Procedure Code	Category	Utilization per 1000	Starting Cost
Exam	92002	Exam	2.0405	32.00
Exam	92004	Exam	1.1336	32.00
Exam	92012	Exam	2.4940	32.00
Exam	92014	Exam	8.1622	32.00
Exam	92015	Exam	3.1742	32.00
Exam	99204	Exam	0.0000	32.00
Exam	99213	Exam	0.4535	32.00
Exam	99214	Exam	0.6802	32.00
Exam	S0620	Exam	0.0000	32.00
Exam	S0621	Exam	1.1336	32.00
Contact Lens Eval/Fitting	92310	Contact Lens Eval/Fitting	6.1216	23.89
Frame	V2020	Frame	20.1787	30.00
Eyeglass Lenses	V2100	Eyeglass Lenses - Single Vision	9.7493	18.79
Eyeglass Lenses	V2103	Eyeglass Lenses - Single Vision	1.3604	20.00
Eyeglass Lenses	V2104	Eyeglass Lenses - Single Vision	0.2267	24.00
Eyeglass Lenses	V2200	Eyeglass Lenses - Bifocal	1.3604	30.00
Eyeglass Lenses	V2202	Eyeglass Lenses - Bifocal	0.2267	36.00
Eyeglass Lenses	V2203	Eyeglass Lenses - Bifocal	0.2267	36.00
Eyeglass Lenses	V2204	Eyeglass Lenses - Bifocal	0.2267	36.00
Eyeglass Lenses	V2205	Eyeglass Lenses - Bifocal	0.2267	36.00
Eyeglass Lenses	V2300	Eyeglass Lenses - Trifocal	6.3484	41.07
Eyeglass Lenses	V2784	Eyeglass Lenses - Specialty	2.4940	72.00
Contact Lenses	S0500	Contact Lenses	1.1336	27.20
Contact Lenses	V2500	Contact Lenses	7.9355	29.94
Contact Lenses	V2520	Contact Lenses	0.4535	48.00
Contact Lenses	V2523	Contact Lenses	0.4535	24.00

c.) Benefit period adjustment

Benefit Period	Frames Adjustment	All Others
12 months	1.00	1.00
24 months	0.70	0.82
Not Covered	0.00	0.00

d.) Copay utilization adjustment

Copay Amount	Adjustment
\$0	1.030
\$5	1.015
\$10	1.000
\$15	0.985
\$20	0.970
\$25	0.955
\$30	0.940
\$35	0.925
\$40	0.910
\$45	0.895
\$50	0.880
\$55	0.865
\$60	0.850
\$65	0.835
\$70	0.820
\$75	0.805
\$80	0.790
\$85	0.775
\$90	0.760
\$95	0.745
\$100	0.730

e.) In-network benefit maximum utilization adjustment

Category	In-network Adj Calc
Frames	$\text{=if}(\text{Maximum} < \text{Cost per Svc}, \text{Max}(0.5, (\text{Maximum}-\text{Cost per Svc})/35 - 0.06), 1)$
Contacts	$\text{=if}(\text{Maximum} < \text{Cost per Svc}, \text{Max}(0.5, (\text{Maximum}-\text{Cost per Svc})/35 + 0.53), 1)$
All Others	$\text{=if}(\text{Maximum} < \text{Cost per Svc}, (\text{Maximum}-\text{Cost per Svc})/50 + 1, 1)$

f.) OON benefit maximum utilization adjustment

Category	OON Adj Calc
Frames	$\text{=if}(\text{Maximum} < \text{Cost per Svc}, (\text{Maximum}-\text{Cost per Svc})/35 + 1, 1)$
Contacts	$\text{=if}(\text{Maximum} < \text{Cost per Svc}, \text{Max}(0.5, (\text{Maximum}-\text{Cost per Svc})/35 + 0.2), 1)$
All Others	$\text{=if}(\text{Maximum} < \text{Cost per Svc}, (\text{Maximum}-\text{Cost per Svc})/50 + 1, 1)$

g.) Low vision aids adjustment (applied to the final PMPM claims cost)

	Min	Max
Per Aid	\$0	\$1000
Factor	1.00	1.05
Per Life	\$0	\$5000
Factor	1.00	1.05

The factor that is applied to the final PMPM claim cost is linearly interpolated between the min and max factors. For example: if a \$500 per aid and \$1500 per lifetime limits are selected, the per aid factor would be 1.025 and the per lifetime factor would be 1.015.

h.) Voluntary adjustment

Voluntary?	Factor
Voluntary	1.35
Non-voluntary	1.00

This factor is also applied to the final PMPM claim cost.

i.) Individual adjustment

Group/Individual	Factor
Individual	1.45
Group	1.00

This factor is also applied to the final PMPM claim cost.



November 22, 2011

District of Columbia
 Department of Insurance
 Securities and Banking
 Jamai Fontaine
 Life & Health Licensing Section
 810 First Street, NE, #701
 Washington, DC 20002

Avalon Insurance Company (“Avalon”) - NAIC #12358– Submission for Approval of Individual Policy Forms

Dear Ms. Fontaine:

Please find enclosed the initial filing of Avalon’s forms and rates for its individual vision products following the issuance of its group accident and health and individual accident and health on September 13, 2011. The forms are listed in the table below in their final format.

Form Number	Name of Form	Intended Use
11VPCOV	Vision Plan Coverage Schedule	Describes coverage for policyholders in the Avalon vision plan. Attached to the Individual Vision Policy.
DC 11VCOC	Individual Vision Policy	Describes coverage for policyholders in the Avalon vision plan. Delivered after receipt of enrollment form and plan premium and before effective date of coverage.
CICD-V11	Change in Coverage Form	Used for changing coverage level of a subscriber (i.e., add dependents to coverage).
SGVISION11	Vision Plan Enrollment Form	Individual enrollment for coverage under the vision plan. Form is attached to a brochure that provides information about the program.
TCD-V11TK	Dental/Vision Enrollment Form	Individual enrollment for coverage under the dental, vision, and discount programs. Form is attached to a brochure that provides information about the programs.

The dental coverage listed in the dental/vision enrollment forms is underwritten by Dominion Dental Services, Inc. ("DDS"). DDS has submitted the following form filing for these enrollment forms - SERFF #DMND-127841138.

See attached Explanations of Variability for all of the above forms.

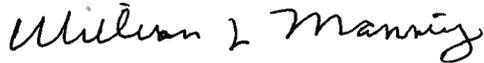
Avalon Insurance Company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted is consistent and complies with the requirements of the Code of the District of Columbia and the regulations promulgated pursuant thereto.

In addition to the forms enclosed, please find the Vision Plan Rate Actuarial Memorandum for group and individual rates. These rates will be effective upon approval.

Avalon Insurance Company markets to large and small employer groups, associations, trade unions, fraternal organizations, and individuals. These forms and rates will be used in the District of Columbia.

If you have any questions concerning this submission, please feel free to contact me at (717) 541-6320 or Melissa Guffey at (703) 518-5000, ext. 3005.

Sincerely,

A handwritten signature in cursive script that reads "William L. Manning".

William Manning
Senior Counsel

Enclosures