

State: District of Columbia

First Filing Company: Dominion Dental Services, Inc., ...

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Health Insurer Fee Rate Filing (Group)

Project Name/Number: /

## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Dominion HCR Fee	DC 09GDSC, 09GDSCa1-DC, DC 13GDSC-GLIC	Revised	Previous State Filing Number: Percent Rate Change Request: 2.04	Dominion-HCR Insurer Fee Memorandum Addendum (Group-DC).pdf,
2		Avalon HCR Fee	DC 11GVSC, 11GVSCa1	Revised	Previous State Filing Number: Percent Rate Change Request: 2.04	Avalon-HCR Insurer Fee Memorandum Addendum (Group-DC).pdf,

**Dominion Dental**  
**DENTAL INSURANCE POLICIES**  
**SELECT (DHMO) and ACCESS PPO GROUP PLANS**  
**ACTUARIAL MEMORANDUM**  
**ADDENDUM**

**Policy Form Numbers:**  
DC 09GDSC, 09GDSCa1-DC & DC 13GDSC-GLIC

**Scope and purpose**

The purpose of this addendum is to amend the previously filed actuarial memorandum and describe the updates to benefits and assumptions 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.

**Proposed Effective Date**

We request an effective date of July 1, 2013 for the Group Plans listed below. Marketing will commence immediately upon approval of this filing.

**Premium Change Rationale**

Under section 9010 of PPACA and Section 1406 of the Reconciliation Act there is a health insurer fee ("HIF") that will be distributed to all entities providing health insurance for any U.S. health risk starting in 2014. Stand-alone dental policies are not excluded from the definition of health insurance, and therefore, Dominion Dental Services, Inc. ("Dominion") will be among the entities that will pay the HIF. The distribution of the HIF to each entity is based on market share. Our market share analysis supports that Dominion will pay a HIF of approximately 2% of total premiums in 2014.

In an effort to prepare for this fee, we are incorporating it into our 2013 rates. The rates will be increased by an amount that will result in an additional 2% to the final premium; the new rates will be calculated as the previously approved rates divided by 0.98. Groups that are covered under form 09GDSCa1 will receive their rate increase on January 1, 2014 as the group rates for these members only change on January 1<sup>st</sup> of each year. They are groups whose members enroll via website and pay their premiums directly through bank draft or credit card.

In summary, the following plans/rates will be increased approximate 2.04% from our currently filed and approved rates:

Select Plan 700-series

Approved on March 4, 2013 under Serff Tracking # DMND-128866554

Select Plan 7000-series

Approved on February 26, 2013 under Serff Tracking #DMND-128901322

Access PPO (currently filed PPO rates)

Last Addendum approved on July 7, 2011 under Serff Tracking #DMND-127141233

### **Reasonableness of Assumptions**

In the actuary's best judgment, the assumptions made in determining these premium rates are reasonable.

### **ACTUARIAL CERTIFICATION**

I, Mark Spitler, am a Fellow 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.

A handwritten signature in black ink, appearing to read 'Mark Spitler', is positioned above the typed name.

Mark Spitler, FSA, MAAA

Senior Director, Actuarial Services  
Capital BlueCross  
(717) 541-6613

April 5, 2013

**Avalon Insurance Company**  
**VISION INSURANCE POLICIES**  
**GROUP PLANS**  
**ACTUARIAL MEMORANDUM**  
**ADDENDUM**

**Policy Form Numbers:**  
DC 11GVSC and 11GVSCa1

**Scope and purpose**

The purpose of this addendum is to amend the previously filed actuarial memorandum and describe the updates to benefits and assumptions 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.

**Proposed Effective Date**

We request an effective date of July 1, 2013 for the Group Plan listed below. Marketing will commence immediately upon approval of this filing.

**Premium Change Rationale**

Under section 9010 of PPACA and Section 1406 of the Reconciliation Act there is a health insurer fee ("HIF") that will be distributed to all entities providing health insurance for any U.S. health risk starting in 2014. Stand-alone vision policies are not excluded from the definition of health insurance, and therefore, Avalon Insurance Company ("Avalon") will be among the entities that will pay the HIF. The distribution of the HIF to each entity is based on market share. Our market share analysis supports that Avalon will pay a HIF of approximately 2% of total premiums in 2014.

In an effort to prepare for this fee, we are incorporating it into our 2013 rates. The rates will be increased by an amount that will result in an additional 2% to the final premium; the new rates will be calculated as the previously approved rates divided by 0.98. Groups that are covered under form 11GVSCa1 will receive their rate increase on January 1, 2014 as the group rates for these members only change on January 1<sup>st</sup> of each year. They are groups whose members enroll via website and pay their premiums directly through bank draft or credit card.

In summary, the following plans/rates will be increased approximate 2.04% from our currently filed and approved rates:

Group Vision Plan

Approved on February 24, 2012 under Serff Tracking #DMND-127841194

**Reasonableness of Assumptions**

In the actuary's best judgment, the assumptions made in determining these premium rates are reasonable.

## ACTUARIAL CERTIFICATION

I, Mark Spitler, am a Fellow 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.

A handwritten signature in black ink, appearing to read 'MS', is positioned above the typed name and title.

Mark Spitler, FSA, MAAA

Senior Director, Actuarial Services  
Capital BlueCross  
(717) 541-6613

April 5, 2013

SERFF Tracking #:

DMND-128975921

State Tracking #:

Company Tracking #:

State: District of Columbia

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Health Insurer Fee Rate Filing (Group)

Project Name/Number: /

First Filing Company: Dominion Dental Services, Inc., ...

## Supporting Document Schedules

<b>Bypassed - Item:</b>	Cover Letter All Filings
<b>Bypass Reason:</b>	See filing description under general information
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Certificate of Authority to File
<b>Bypass Reason:</b>	N/A
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Actuarial Memorandum
<b>Comments:</b>	
<b>Attachment(s):</b>	Dominion-HCR Insurer Fee Memorandum Addendum (Group-DC).pdf Avalon-HCR Insurer Fee Memorandum Addendum (Group-DC).pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Actuarial Justification
<b>Bypass Reason:</b>	See Memorandums above.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
<b>Bypass Reason:</b>	See supporting documents for previously approved filings.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

SERFF Tracking #:

DMND-128975921

State Tracking #:

Company Tracking #:

State: District of Columbia

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Health Insurer Fee Rate Filing (Group)

Project Name/Number: /

First Filing Company: Dominion Dental Services, Inc., ...

<b>Bypassed - Item:</b>	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
<b>Bypass Reason:</b>	See supporting documents for previously approved filings.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Bypassed - Item:</b>	Actuarial Memorandum and Certifications
<b>Bypass Reason:</b>	N/A
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Bypassed - Item:</b>	Actuarial Memorandum and Certifications
<b>Bypass Reason:</b>	N/A
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Bypassed - Item:</b>	Unified Rate Review Template
<b>Bypass Reason:</b>	N/A
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Bypassed - Item:</b>	Unified Rate Review Template
<b>Bypass Reason:</b>	N/A
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Previously approved rate filings
<b>Comments:</b>	

**SERFF Tracking #:**

DMND-128975921

**State Tracking #:**

**Company Tracking #:**

**State:**

District of Columbia

**First Filing Company:**

Dominion Dental Services, Inc., ...

**TOI/Sub-TOI:**

H10G Group Health - Dental/H10G.000 Health Dental

**Product Name:**

Health Insurer Fee Rate Filing (Group)

**Project Name/Number:**

/

<b>Attachment(s):</b>	Avalon Group Filing DMND-127841194 (Approved 2-24-12).pdf Select Plan 700 Series Filing DMND-128866554 (Approved 3-4-13).pdf Select Plan 7000 Series Filing DMND-128901322 (Approved 2-26-13).pdf Access PPO Addendum Filing DMND-127141233 (Approved 7-7-11).pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

**Dominion Dental**  
**DENTAL INSURANCE POLICIES**  
**SELECT (DHMO) and ACCESS PPO GROUP PLANS**  
**ACTUARIAL MEMORANDUM**  
**ADDENDUM**

**Policy Form Numbers:**  
DC 09GDSC, 09GDSCa1-DC & DC 13GDSC-GLIC

**Scope and purpose**

The purpose of this addendum is to amend the previously filed actuarial memorandum and describe the updates to benefits and assumptions 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.

**Proposed Effective Date**

We request an effective date of July 1, 2013 for the Group Plans listed below. Marketing will commence immediately upon approval of this filing.

**Premium Change Rationale**

Under section 9010 of PPACA and Section 1406 of the Reconciliation Act there is a health insurer fee ("HIF") that will be distributed to all entities providing health insurance for any U.S. health risk starting in 2014. Stand-alone dental policies are not excluded from the definition of health insurance, and therefore, Dominion Dental Services, Inc. ("Dominion") will be among the entities that will pay the HIF. The distribution of the HIF to each entity is based on market share. Our market share analysis supports that Dominion will pay a HIF of approximately 2% of total premiums in 2014.

In an effort to prepare for this fee, we are incorporating it into our 2013 rates. The rates will be increased by an amount that will result in an additional 2% to the final premium; the new rates will be calculated as the previously approved rates divided by 0.98. Groups that are covered under form 09GDSCa1 will receive their rate increase on January 1, 2014 as the group rates for these members only change on January 1<sup>st</sup> of each year. They are groups whose members enroll via website and pay their premiums directly through bank draft or credit card.

In summary, the following plans/rates will be increased approximate 2.04% from our currently filed and approved rates:

Select Plan 700-series

Approved on March 4, 2013 under Serff Tracking # DMND-128866554

Select Plan 7000-series

Approved on February 26, 2013 under Serff Tracking #DMND-128901322

Access PPO (currently filed PPO rates)

Last Addendum approved on July 7, 2011 under Serff Tracking #DMND-127141233

### **Reasonableness of Assumptions**

In the actuary's best judgment, the assumptions made in determining these premium rates are reasonable.

### **ACTUARIAL CERTIFICATION**

I, Mark Spitler, am a Fellow 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.

A handwritten signature in black ink, appearing to read 'M. Spitler', is written in a cursive style.

Mark Spitler, FSA, MAAA

Senior Director, Actuarial Services  
Capital BlueCross  
(717) 541-6613

April 5, 2013

**Avalon Insurance Company**  
**VISION INSURANCE POLICIES**  
**GROUP PLANS**  
**ACTUARIAL MEMORANDUM**  
**ADDENDUM**

**Policy Form Numbers:**  
DC 11GVSC and 11GVSCa1

**Scope and purpose**

The purpose of this addendum is to amend the previously filed actuarial memorandum and describe the updates to benefits and assumptions 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.

**Proposed Effective Date**

We request an effective date of July 1, 2013 for the Group Plan listed below. Marketing will commence immediately upon approval of this filing.

**Premium Change Rationale**

Under section 9010 of PPACA and Section 1406 of the Reconciliation Act there is a health insurer fee ("HIF") that will be distributed to all entities providing health insurance for any U.S. health risk starting in 2014. Stand-alone vision policies are not excluded from the definition of health insurance, and therefore, Avalon Insurance Company ("Avalon") will be among the entities that will pay the HIF. The distribution of the HIF to each entity is based on market share. Our market share analysis supports that Avalon will pay a HIF of approximately 2% of total premiums in 2014.

In an effort to prepare for this fee, we are incorporating it into our 2013 rates. The rates will be increased by an amount that will result in an additional 2% to the final premium; the new rates will be calculated as the previously approved rates divided by 0.98. Groups that are covered under form 11GVSCa1 will receive their rate increase on January 1, 2014 as the group rates for these members only change on January 1<sup>st</sup> of each year. They are groups whose members enroll via website and pay their premiums directly through bank draft or credit card.

In summary, the following plans/rates will be increased approximate 2.04% from our currently filed and approved rates:

Group Vision Plan

Approved on February 24, 2012 under Serff Tracking #DMND-127841194

**Reasonableness of Assumptions**

In the actuary's best judgment, the assumptions made in determining these premium rates are reasonable.

## **ACTUARIAL CERTIFICATION**

I, Mark Spitler, am a Fellow 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.

A handwritten signature in black ink, appearing to read 'MS', is positioned above the typed name and title.

Mark Spitler, FSA, MAAA

Senior Director, Actuarial Services  
Capital BlueCross  
(717) 541-6613

April 5, 2013

**State:** District of Columbia **Filing Company:** Avalon Insurance Company  
**TOI/Sub-TOI:** H20G Group Health - Vision/H20G.000 Health - Vision  
**Product Name:** Avalon Group Vision Plan Forms/Rates  
**Project Name/Number:** /

## Filing at a Glance

Company: Avalon Insurance Company  
Product Name: Avalon Group Vision Plan Forms/Rates  
State: District of Columbia  
TOI: H20G Group Health - Vision  
Sub-TOI: H20G.000 Health - Vision  
Filing Type: Rate  
Date Submitted: 11/29/2011  
SERFF Tr Num: DMND-127841194  
SERFF Status: Closed-APPROVED  
State Tr Num:  
State Status:  
Co Tr Num:  
Co Status:  
Implementation On Approval  
Date Requested:  
Author(s): Melissa Guffey  
Reviewer(s): Efren Tanhehco (primary)  
Disposition Date: 02/24/2012  
Disposition Status: APPROVED  
Implementation Date:

**State:** District of Columbia **Filing Company:** Avalon Insurance Company  
**TOI/Sub-TOI:** H2OG Group Health - Vision/H2OG.000 Health - Vision  
**Product Name:** Avalon Group Vision Plan Forms/Rates  
**Project Name/Number:** /

### General Information

Project Name: Status of Filing in Domicile: Pending  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: New Submission Group Market Size: Small and Large  
 Group Market Type: Employer, Association Overall Rate Impact:  
 Filing Status Changed: 02/24/2012 Company Status Changed:  
 State Status Changed: Deemer Date:  
 Created By: Melissa Guffey Submitted By: Melissa Guffey  
 Corresponding Filing Tracking Number:

Filing Description:  
 Avalon Group Vision Plan Forms/Rates

### Company and Contact

#### Filing Contact Information

Melissa Guffey, Senior Regulatory Analyst mguffey@dominiondental.com  
 115 S. Union Street 703-518-5000 [Phone] 3005 [Ext]  
 Suite 300 703-859-7716 [FAX]  
 Alexandria, VA 22314

#### Filing Company Information

Avalon Insurance Company	CoCode: 12358	State of Domicile:
2500 Elmerton Avenue	Group Code: 1230	Pennsylvania
Harrisburg, PA 17177	Group Name: Capital BlueCross	Company Type: Life & Health
(717) 541-7577 ext. [Phone]	FEIN Number: 76-0801682	Insurer
		State ID Number:

### Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:

**SERFF Tracking #:**

DMND-127841194

**State Tracking #:****Company Tracking #:****State:**

District of Columbia

**Filing Company:**

Avalon Insurance Company

**TOI/Sub-TOI:**

H20G Group Health - Vision/H20G.000 Health - Vision

**Product Name:**

Avalon Group Vision Plan Forms/Rates

**Project Name/Number:**

/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Robert Nkojo	02/24/2012	02/24/2012

### Filing Notes

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

**State:** District of Columbia  
**TOI/Sub-TOI:** H20G Group Health - Vision/H20G.000 Health - Vision  
**Product Name:** Avalon Group Vision Plan Forms/Rates  
**Filing Company:** Avalon Insurance Company  
**Project Name/Number:** /

## Disposition

Disposition Date: 02/24/2012

Implementation Date:

Status: APPROVED

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Actuarial Justification		Yes
Supporting Document	Explanation of Variability for forms other than 11VPCOV		Yes
Supporting Document	Transmittal Letter		Yes
Form	Vision Plan Coverage Schedule		Yes
Form	Group Certificate of Coverage Policy		Yes
Form	Group Vision Service Contract		Yes
Form	Group Vision Service Contract Addendum		Yes
Form	Change in Coverage Form		Yes
Form	Dental/Vision Enrollment Form		Yes
Form	Dental/Vision Enrollment Form		Yes
Form	Dental/Vision Enrollment Form		Yes
Form	Dental/Vision Enrollment Form		Yes
Form	Dental/Vision Enrollment Form		Yes

---

**State:** District of Columbia **Filing Company:** Avalon Insurance Company  
**TOI/Sub-TOI:** H20G Group Health - Vision/H20G.000 Health - Vision  
**Product Name:** Avalon Group Vision Plan Forms/Rates  
**Project Name/Number:** /

## Note To Filer

**Created By:**

Efren Tanhehco on 01/30/2012 09:38 AM

**Last Edited By:**

Efren Tanhehco

**Submitted On:**

01/30/2012 09:38 AM

**Subject:**

Review Status

**Comments:**

Still in progress --- secondary reviewer just assigned by primary reviewer

State:

District of Columbia

Filing Company:

Avalon Insurance Company

TOI/Sub-TOI:

H20G Group Health - Vision/H20G.000 Health - Vision

Product Name:

Avalon Group Vision Plan Forms/Rates

Project Name/Number:

/

## Form Schedule

### Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Vision Plan Coverage Schedule	11VPCOV	OUT	Initial		37.000	11VPCOV.pdf Explanation of Variability Statement Coverage Schedule.pdf
2		Group Certificate of Coverage Policy	DC 11GVCOC	CER	Initial		35.500	DC 11GVCOC.pdf
3		Group Vision Service Contract	DC 11GVSC	POL	Initial		44.200	DC 11GVSC.pdf
4		Group Vision Service Contract Addendum	11GVSCa1	POL	Initial		40.300	11GVSCa1.pdf
5		Change in Coverage Form	CICD-V11	OTH	Initial			CICD-V11.pdf
6		Dental/Vision Enrollment Form	CHOICE D-V11	AEF	Initial			CHOICE D-V11.pdf
7		Dental/Vision Enrollment Form	TCD-V11	AEF	Initial			TCD-V11.pdf
8		Dental/Vision Enrollment Form	PO-V11	AEF	Initial			PO-V11.pdf
9		Dental/Vision Enrollment Form	SO-V11	AEF	Initial			SO-V11.pdf
10		Dental/Vision Enrollment Form	EGVISION11	AEF	Initial			EGVISION11.pdf

**SERFF Tracking #:**

DMND-127841194

**State Tracking #:****Company Tracking #:****State:**

District of Columbia

**Filing Company:**

Avalon Insurance Company

**TOI/Sub-TOI:**

H20G Group Health - Vision/H20G.000 Health - Vision

**Product Name:**

Avalon Group Vision Plan Forms/Rates

**Project Name/Number:**

/

**Form Type Legend:**

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

## [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 Allowances<sup>1</sup>

##### 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

<sup>1</sup> 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.]



## [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.

**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 Certificate 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 [26<sup>th</sup>] birthday. At the Group's request, 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. **Group** shall mean the organization or employing unit with which the Subscriber is associated and which has executed the Group Service Contract.
- H. **Materials** shall mean lenses, frames and contact lenses.
- I. **Member** shall mean any individual Subscriber or eligible family Dependent entitled to receive services by reason of the Contract.
- J. **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.
- K. **Premiums** shall mean amounts payable on a regular prepayment basis by or for the Subscriber to the Plan.
- L. **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.
- M. **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 Premium 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 Group.
- B. All persons who have enrolled in the Plan and paid the appropriate Premium between the 17th day of the month and the last day of the month shall be eligible for Benefits commencing on the 1<sup>st</sup> day of the second month or on any date mutually agreed upon by Plan and Group.
- 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 Premium was made to Plan. If payment is not made in full by the Group 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 Group after the first payment. If notice of intention to terminate the Contract is received during the grace period, the Plan may collect Premium 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. Upon the date of Dependents attaining the age of [26] years or marriage prior to that date (Subject to Part I-D).
- C. Upon violation of the terms of this Contract, fraud or deception in the use of services, or termination of the Group Contract under which the Member is covered. Coverage will be canceled after the 31st day after written notice is mailed to the Subscriber.

Group coverage will renew for [one (1) year] periods in the absence of written termination notification by Group at least thirty (30) days in advance of expiration of the term of the Contract.

#### Part IV. PREMIUMS

- A. All Premiums are payable on or before the 17th day of the month preceding the month in which services may be 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].

#### Part V. COORDINATION OF BENEFITS

All covered Benefits 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 failure of another group 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.

(Go to next column labeled 7)

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



## Group Certificate of Coverage

## Vision Insurance

**Limited Benefit**  
**Please Read Carefully**

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

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.

#### **Part VI. 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 VII. 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 Group sixty (60) days prior written notice.

#### **Part VIII. CONTINUATION OF COVERAGE**

Upon termination of their eligibility for coverage under the Plan, Subscribers and their Dependents may have the right to continue coverage for a period of time under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Groups may also elect for their Members to receive continued coverage for a 90-day period immediately following the date of termination, at the Premiums applicable to the Group Contract, provided that the Subscriber pays to the Group the Premiums in full for the 90-day period. The Group will notify the Member of their options for continuation of coverage.

#### **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 60 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**

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., 6<sup>th</sup> 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., 7<sup>th</sup> 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 Group Contract, executed on behalf of Subscribers, this Certificate of Coverage (including any attachments thereto), and any applications of the Group and Subscribers constitute the entire Contract between the parties. A copy of any application of the Group shall be attached to the Contract when issued. 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].



**Avalon Insurance Company**  
2500 Elmerton Avenue, Harrisburg, PA 17177 • (717) 541-7000

**GROUP VISION SERVICE CONTRACT**

This Agreement is made by and between Avalon Insurance Company (hereinafter referred to as Plan), and  
(hereinafter referred to as Group). Effective Date \_\_\_\_\_ Time 12:01 A.M.

Vision Plan # \_\_\_\_\_

Monthly Plan Premiums:

Subscriber	\$ _____
Subscriber and One Dependent	\$ _____
Subscriber and Two or More Dependents	\$ _____
Other _____	\$ _____

Term (Months) \_\_\_\_\_

Billing Fee (If Electronic Funds Transfer is Not Utilized) \_\_\_\_\_

**GENERAL PURPOSE:** Plan was established to provide a wide range of vision care services to Subscribers and their eligible Dependents.

- I. **ENTIRE CONTRACT:** This Agreement, including attachments hereto, constitutes the entire Contract between the parties. 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.
- II. **PREMIUMS:** All Premiums are payable on or before the 17th day of the month preceding the month in which services may be rendered. 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 Transfer is not utilized, payments should be mailed to [Dominion Dental Services USA, Inc.], [P.O. Box 75314, Charlotte, NC 28275-0314].
- III. **GRACE PERIOD:** If payment is not made in full by the Group on or prior to the date due, as specified in Part II, a grace period of 31 days from the last date of coverage shall be granted to the Group 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.
- IV. **CHANGE IN SERVICE:** Plan reserves the right to change the Premiums or the Plan benefits after completion of the original term of this Contract. No change will be made without giving the Group sixty (60) days prior written notice.
- V. **DURATION OF GROUP CONTRACT:**  
In the absence of fraud or a violation of the terms of this Contract, Group coverage will renew for [one year] periods unless written termination notification is received from Group at least 30 days in advance of expiration of the term of this Contract.

**VI. CONFORMITY TO LAW:**

This Contract is governed by District of Columbia law. Any provision of this Contract which, as of its effective date, is in conflict with the laws of the District of Columbia is amended to conform to the minimum requirements of such laws.

**VII. ARBITRATION:**

In the event of any controversy between Group, Subscriber, and the Plan, the same shall be resolved in accordance with the Plan Complaint Procedures. In the event that the Complaint Procedures do not resolve the dispute between Group and the Plan, the Group and Plan may agree to submit it to binding arbitration. Said arbitration shall be conducted and governed by the provisions of District of Columbia law.

**CERTIFICATE PROVISIONS MADE PART OF THIS CONTRACT**

The remainder of this Contract consists of provisions shown in the attached Certificate of Coverage issued to Subscribers. The provisions described in the Certificate of Coverage are part of this Contract. Riders and amendments adding or changing the provisions of the Certificate of Coverage are also made part of this Contract.

**IN WITNESS THERETO**, the parties hereto have caused this Agreement to be executed as of the effective date and year first above written.

GROUP

AVALON INSURANCE COMPANY

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ATTACHMENTS:      Group Certificate of Coverage, List of Participating Providers and Complaint Procedures



**eDental PROGRAM**  
**GROUP VISION SERVICE CONTRACT ADDENDUM**

The following terms and conditions supplement or supersede, where specifically applicable, the Group Vision Service Contract (GVSC) between \_\_\_\_\_ (Group), and Avalon Insurance Company (Plan). This addendum addresses specific differences for group vision plan administration applicable to the Plan's eDental Program. All remaining terms and conditions and the effective date of the GVSC shall apply.

**REVISED GVSC SECTIONS:**

**CHANGE IN SERVICE**

- 1) Plan reserves the right to change the Premiums and/or the Plan benefits for new enrollees in the Group eDental Program on January 1 of [each year]. No change will be made without giving the Group sixty (60) days prior written notice.
- 2) Premiums and Plan benefits for enrolled Subscribers will remain in place for [12 months] following the Subscriber's initial effective date.

**SECTIONS ADDED TO GVSC:**

**TERM OF GROUP CONTRACT**

The term of Contract for enrolled Subscribers will be [12 months] following the Subscriber's effective date of coverage.

**MARKETING AND PROMOTION**

Group agrees to provide no less than three (3) e-mail promotions, postal mailings, or large scale enrollment events for its general membership at equal intervals during the year. Content, design, and timing of the promotions will be mutually agreed upon prior to the event.

Accepted:

(Group)

Avalon Insurance Company

By: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

# 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 <sup>1</sup> ] | <input type="checkbox"/> Terminate Subscriber | <input type="checkbox"/> Delete Dependents         |
| <input type="checkbox"/> [Access PPO Plan <sup>1</sup> ]        | <input type="checkbox"/> Split Dental Centers | <input type="checkbox"/> Change Dental Office      |
| <input type="checkbox"/> [Avalon Vision <sup>2</sup> ]          |   | ([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.
----------------------	-----------------------------------	--------------------------	-----------------------------------

<sup>1</sup> The dental plans are underwritten by Dominion Dental Services, Inc.

<sup>2</sup> 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]

**Dental/Vision Enrollment Card**

**DENTAL**      I choose [the Dominion Select Plan<sup>1</sup>]  
**SELECT ONE:**    I choose [the Dominion Access PPO 1<sup>1</sup>]  
                           I choose [the Dominion Access PPO 2<sup>1</sup>]

**VISION**      I choose [the Avalon vision<sup>2</sup> plan 1]  
**SELECT ONE:**    I choose [the Avalon vision<sup>2</sup> 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]			Hire Date [01/24/11]	

**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]

<b>[SELECT PLAN]</b> 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]**

<sup>1</sup> The dental plans are underwritten by Dominion Dental Services, Inc.

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

**CHOICE D-V11**  
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 Program<sup>1</sup>]  
**SELECT ONE:**     I choose [the Dominion Select Plan<sup>2</sup>]  
                            I choose [the Dominion Access PPO<sup>2</sup>]

**VISION**     I choose [the Avalon vision<sup>3</sup> plan 1]  
**SELECT ONE:**     I choose [the Avalon vision<sup>3</sup> 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]			Hire Date [01/24/11]	

### 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]**

<sup>1</sup> 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.

<sup>2</sup> The dental plans are underwritten by Dominion Dental Services, Inc.

<sup>3</sup> 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 SELECT ONE:**  I choose [the Dominion Access PPO 1<sup>1</sup>]  
 I choose [the Dominion Access PPO 2<sup>1</sup>]

**VISION SELECT ONE:**  I choose [the Avalon vision<sup>2</sup> plan 1]  
 I choose [the Avalon vision<sup>2</sup> 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]			Hire Date [01/24/11]	

### 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]

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]**

<sup>1</sup> The dental plans are underwritten by Dominion Dental Services, Inc.

<sup>2</sup> 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 SELECT ONE:**  I choose [the Dominion Select Plan 1<sup>1</sup>]  
 I choose [the Dominion Select Plan 2<sup>1</sup>]]

**VISION SELECT ONE:**  I choose [the Avalon vision<sup>2</sup> plan 1]  
 I choose [the Avalon vision<sup>2</sup> 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]			Hire Date [01/24/11]	

**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]

**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]**

<sup>1</sup> The dental plan is underwritten by Dominion Dental Services, Inc.

<sup>2</sup> 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.

**SELECT ONE:**    I choose [the Avalon vision<sup>1</sup> plan 1]  
 I choose [the Avalon vision<sup>1</sup> 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 [703-123-4567]	
City [Alexandria]	State [VA]	ZIP [22314]	Work Phone [703-518-5000]	
Email Address [msmith528@email.com]			Hire Date [1/24/11]	

**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 # [5678]	Coverage Eff. Date [11/01/11]	Plan # [23456]	Agent/Broker # [1234]
--------------------------------------	-------------------	----------------------------------	-------------------	--------------------------

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

<sup>1</sup> 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.

SERFF Tracking #:

DMND-127841194

State Tracking #:

Company Tracking #:

State: District of Columbia

Filing Company:

Avalon Insurance Company

TOI/Sub-TOI: H20G Group Health - Vision/H20G.000 Health - Vision

Product Name: Avalon Group Vision Plan Forms/Rates

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Actuarial Justification		
Comments:			
Attachment(s):			
Avalon Insurance Company Actuarial Memorandum - DC.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variability for forms other than 11VPCOV		
Comments:			
Attachment(s):			
Explanation of Variability Statement all documents other than Coverage Schedule (DC)-Group.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Transmittal Letter		
Comments:			
Attachment(s):			
Transmittal Letter-Group.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.

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>
Group Certificate of Coverage	DC 11VGCOC	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.
Group Certificate of Coverage	DC 11VGCOC	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.
Group Certificate of Coverage	DC 11VGCOC	Cover page	[115 S. Union Street, Suite 300, Alexandria, Virginia 22314]	Any address may be inserted. Allows us to change office location.
Group Certificate of Coverage	DC 11VGCOC	Cover page	[(703) 518-5000], [(888) 518-5338]	Any phone number may be inserted. Allows us to change phone numbers.
Group Certificate of Coverage	DC 11VGCOC	Intro. – 2 <sup>nd</sup> 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
Group Certificate of Coverage	DC 11VGCOC	Intro. – 2 <sup>nd</sup> paragraph	[115 S. Union Street, Suite 300, Alexandria, Virginia 22314]	Any address may be inserted. Allows us to change office location.
Group Certificate of Coverage	DC 11VGCOC	Intro. – 2 <sup>nd</sup> paragraph	[(703) 518-5000]	Any phone number may be inserted. Allows us to change phone numbers.
Group Certificate of Coverage	DC 11VGCOC	Part I-A. Dependent	[26 <sup>th</sup> ]	Dependent age limit max is 26 years of age. This allows flexibility in the event the age limit requested is less than 26.
Group Certificate of Coverage	DC 11VGCOC	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.
Group Certificate of Coverage	DC 11VGCOC	Part III. Termination or Cancellation	[one (1) year]	Allows us flexibility with the renewal period.
Group Certificate of Coverage	DC 11VGCOC	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.
Group Certificate of Coverage	DC 11VGCOC	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.
Group Certificate of Coverage	DC 11VGCOC	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
Group Certificate of Coverage	DC 11VGCOC	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.
Group Certificate of Coverage	DC 11VGCOC	Part X. COMPLAINTS AND GRIEVANCES	[(800) 672-7723]	Any phone number may be inserted. Allows us to change phone numbers.
Group Certificate of Coverage	DC 11VGCOC	Attachments	[(888) 518-5338]	Any phone number may be inserted. Allows us to change phone numbers.
Group Vision Service Contract	DC 11GVSC	Part II. 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.
Group Vision Service Contract	DC 11GVSC	Part II. Premiums	[P.O. Box 75314, Charlotte, NC 28275-0314]	Any address may be used. Allows us to change the address for premium remittance.
Group Vision Service Contract	DC 11GVSC	Part V. Duration of Group Contract	[one year]	Allows us flexibility with the renewal period.
Group Vision Service Contract Addendum	11GVSCa1	Change in Service	[each year]	Allows us flexibility with the renewal period.
Group Vision Service Contract Addendum	11GVSCa1	Change in Service	[12 months]	Allows us flexibility with the renewal period.



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 Group Policy Forms

Dear Ms. Fontaine:

Please find enclosed the initial filing of Avalon’s forms and rates for its group 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.

<b>Form Number</b>	<b>Name of Form</b>	<b>Intended Use</b>
11VPCOV	Vision Plan Coverage Schedule	Describes coverage for group policyholders and subscribers in the Avalon vision plan. Attached to the Group Certificate of Coverage.
DC 11GVCOC	Group Certificate of Coverage	Describes coverage for group policyholders and subscribers in the Avalon vision plan. Attached to the Group Vision Service Contract and delivered to subscriber after receipt of enrollment form and plan premium and before effective date of coverage.
DC 11GVSC	Group Vision Service Contract	Contract for vision coverage between group policyholder and Avalon.
11GVSCa1	Group Vision Service Contract Addendum	Addendum to Group Vision Service Contract between group policyholder and Avalon. Addendum is used for the eDental program, whereby members of associations can enroll in one of three dental plan options and the vision plan.
CICD-V11	Change in Coverage Form	Used for changing coverage level of a subscriber (i.e., add dependents to coverage).

CHOICE D-V11	Dental/Vision Enrollment Form	Individual enrollment for coverage under the dental and vision group benefit plans. Form is attached to a brochure that provides information about the plans.
TCD-V11	Dental/Vision Enrollment Form	Individual enrollment for coverage under the dental and vision group benefit plans and the individual discount programs. Form is attached to a brochure that provides information about the programs.
PO-V11	Dental/Vision Enrollment Form	Individual enrollment for coverage under the dental and vision group benefit plans. Form is attached to a brochure that provides information about the programs.
SO-V11	Dental/Vision Enrollment Form	Individual enrollment for coverage under the dental and vision group benefit plans. Form is attached to a brochure that provides information about the programs.
EGVISION11	Vision Plan Enrollment Form	Individual enrollment for coverage under the vision group benefit plan. Form is attached to a brochure that provides information about the program.

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-127841149.

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

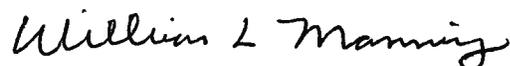
Avalon Insurance Company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted is consistent and complies with the requirements of the Code of the District of Columbia and the regulations promulgated pursuant thereto.

In addition to the forms enclosed, please find the Vision Plan Rate Actuarial Memorandum for group and individual rates. For group coverage, these are the rates provided to the group for each individual enrolled in the plan and 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,



William Manning  
Senior Counsel

Enclosures

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

## Filing at a Glance

Company: Dominion Dental Services, Inc.  
Product Name: Select Plan Series (700) 2013 rates  
State: District of Columbia  
TOI: H10G Group Health - Dental  
Sub-TOI: H10G.000 Health Dental  
Filing Type: Rate  
Date Submitted: 01/25/2013  
SERFF Tr Num: DMND-128866554  
SERFF Status: Closed-APPROVED  
State Tr Num:  
State Status:  
Co Tr Num: 121012  
Co Status:  
Implementation: 07/01/2013  
Date Requested:  
Author(s): Melissa Guffey  
Reviewer(s): Darniece Shirley (primary), Carolyn King  
Disposition Date: 03/04/2013  
Disposition Status: APPROVED  
Implementation Date: 07/01/2013

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

## General Information

Project Name: Status of Filing in Domicile: Pending  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: File & Use Domicile Status Comments: The filing in Virginia was filed at the same time as this filing and is currently pending their approval.  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: New Submission Group Market Size: Small and Large  
 Group Market Type: Employer Overall Rate Impact: 4.5%  
 Filing Status Changed: 03/04/2013 Company Status Changed:  
 State Status Changed: Deemer Date:  
 Created By: Melissa Guffey Submitted By: Melissa Guffey  
 Corresponding Filing Tracking Number: DMND-127807343 & DMND-128671058

### Filing Description:

For the 2013 year, we have developed a new Select Plan Series to upgrade from our outdated copayment and rate schedule from the previously approved 600 Series Select Plans. The 700 Select Plan rates will be administered for new and renewal business once approved.

The Select Plan 700 Series Plans are the monthly group premium rates which correspond to form numbers DC 09GDSC and 09GDSCa1-DC which were approved on January 11, 2011.

The Select Plan 700-Series are an upgraded plan from the previously approved Select Plan 600-Series (SERFF Tracking# DMND-127807344 and attached hereto under the supporting documentation tab). We are requesting an increase of 4.5% on the 600 Series Select Plan rates that were filed and approved on January 11, 2012. These rates are provided to the group for each individual enrolled in the plan and will be effective July 1, 2013.

No other regulatory body has withdrawn approval of the forms above for any reason, including the reason that the forms contained one or more provisions that were deemed to be misleading, deceptive or contrary to public policy.

Our programs are sold to large and small employer groups, associations, trade unions, fraternal organizations, and individuals.

Please do not hesitate to contact me at 703-518-5000, x3005 if you need any further information.

## Company and Contact

### Filing Contact Information

Melissa Guffey, Senior Regulatory Analyst mguffey@dominiondental.com  
 115 S. Union Street 703-518-5000 [Phone] 3005 [Ext]  
 Suite 300 703-859-7716 [FAX]  
 Alexandria, VA 22314

---

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

**Filing Company Information**

Dominion Dental Services, Inc.  
115 S. Union Street  
Suite 300  
Alexandria, VA 22314  
(703) 518-5000 ext. 3047[Phone]

CoCode: 95657  
Group Code: 1230  
Group Name: Capital Blue Cross  
FEIN Number: 54-1808292

State of Domicile: Virginia  
Company Type: Dental Plan  
Organizatoion  
State ID Number:

---

**Filing Fees**

Fee Required? No  
Retaliatory? No  
Fee Explanation:

SERFF Tracking #:

DMND-128866554

State Tracking #:

Company Tracking #:

121012

State: District of Columbia

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (700) 2013 rates

Project Name/Number: /

Filing Company: Dominion Dental Services, Inc.

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Darniece Shirley	03/04/2013	03/04/2013

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Darniece Shirley	02/04/2013	02/04/2013

#### Response Letters

Responded By	Created On	Date Submitted
Melissa Guffey	02/22/2013	02/22/2013

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Break-out filing from DMND-128803830	Note To Reviewer	Melissa Guffey	01/25/2013	01/25/2013

State: District of Columbia

Filing Company:

Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (700) 2013 rates

Project Name/Number: /

## Disposition

Disposition Date: 03/04/2013

Implementation Date: 07/01/2013

Status: APPROVED

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Dominion Dental Services, Inc.	4.500%	4.500%	\$4,230	19	\$94,020	5.000%	5.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter All Filings		Yes
Supporting Document	Certificate of Authority to File		Yes
Supporting Document	Actuarial Memorandum		Yes
Supporting Document	Actuarial Justification		Yes
Supporting Document	District of Columbia and Countrywide Loss Ratio Analysis (P&C)		Yes
Supporting Document	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)		Yes
Supporting Document	Rate Summary Worksheet		Yes
Supporting Document	Select Plan 700-Series Supporting Documentation		Yes
Rate	Select Plan 700-series rates		Yes

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	02/04/2013
Submitted Date	02/04/2013
Respond By Date	02/25/2013

Dear Melissa Guffey,

### **Introduction:**

Thank you for your recent filing. Please see below for additional information requested to continue review of the rate filing.

### **Objection 1**

Comments: Please correct, via post-submission updated the Rate Review Data Detail to include the minimum and maximum %age change to any one policyholder.

### **Objection 2**

Comments: How many covered lives, do the 84 in-force policies represent? Please present the 3-yr and life-of-policy loss information for DC and nationwide.

### **Objection 3**

- Actuarial Memorandum (Supporting Document)
- Select Plan 700-Series Supporting Documentation (Supporting Document)
- Select Plan 700-series rates, [DC 09GDSC, 09GDSCa1-DC] (Rate)

Comments: Is the purpose of the rate filing for the 600-series to bring it up to the co-payment and rate schedule levels of the 700-series plans?

### **Objection 4**

- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- Select Plan 700-Series Supporting Documentation (Supporting Document)
- Select Plan 700-series rates, [DC 09GDSC, 09GDSCa1-DC] (Rate)

Comments: How long will the Select Plan 600-series continue to be sold? Please provide additional details for the Carriers future intention for this product?

### **Conclusion:**

Sincerely,  
Darniece Shirley

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/22/2013  
Submitted Date 02/22/2013

Dear Darniece Shirley,

### **Introduction:**

Please see comments below.

### **Response 1**

#### **Comments:**

The post-submission update has been submitted to reflect the min/max percentage change to any one policyholder.

### **Related Objection 1**

Comments: Please correct, via post-submission updated the Rate Review Data Detail to include the minimum and maximum %age change to any one policyholder.

### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### **Response 2**

#### **Comments:**

The 84 number originally presented was inaccurate, we currently only have 19 policyholders (groups) in-force that represent a total of 526 members.

In response to the second part of your question, this is only the 2nd rate filing increase for our company as we were licensed in 2010. The initial filing was on 12/6/10 with an effective date upon approval. The first increase requesting a 5% increase was filed on 11/9/11 with an effective date of 4/1/12 which was approved on 1/11/12. This rate increase is requesting a 4.5% increase off of the 600-series rates. Below is the policy loss experience requested which is also listed under supporting documentation.

DC loss experience, current 62.384%

DC loss experience, 36-mos 60.091%

DC loss experience, Lifetime 60.636%

Nationwide loss experience, current: 57.169%

Nationwide loss experience, 36-mos 56.872%

Nationwide loss experience, Lifetime 56.801%

### **Related Objection 2**

Comments: How many covered lives, do the 84 in-force policies represent? Please present the 3-yr and life-of-policy loss information for DC and nationwide.

### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### **Response 3**

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

**Comments:**

Yes, the Select Plan 700-series should be regarded as a refresh of the Select Plan 600-series. In an effort to keep the plan modern and competitive, several obsolete CDT codes have been removed from the schedule and several new procedures are added to the schedule. The Exclusions and Limitations were updated so that they are consistent among all our filed states. The copays of many procedure codes were increased. The relationship among copays for similar procedures was improved.

**Related Objection 3**

Applies To:

- Select Plan 700-series rates, [DC 09GDSC, 09GDSCa1-DC] (Rate)
- Actuarial Memorandum (Supporting Document)
- Select Plan 700-Series Supporting Documentation (Supporting Document)

Comments: Is the purpose of the rate filing for the 600-series to bring it up to the co-payment and rate schedule levels of the 700-series plans?

**Changed Items:**

No Supporting Documents changed.  
No Form Schedule items changed.  
No Rate/Rule Schedule items changed.

**Response 4****Comments:**

The ultimate goal is to convert all current 600-series group policyholders over to the 700-series upon their renewal; however, if a group wants to remain on the 600-series we will continue to offer the option to them. For new groups, we will only offer the 700-series plans, again to remain competitive and modern.

**Related Objection 4**

Applies To:

- Select Plan 700-series rates, [DC 09GDSC, 09GDSCa1-DC] (Rate)
- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- Select Plan 700-Series Supporting Documentation (Supporting Document)

Comments: How long will the Select Plan 600-series continue to be sold? Please provide additional details for the Carriers future intention for this product?

**Changed Items:**

No Supporting Documents changed.  
No Form Schedule items changed.  
No Rate/Rule Schedule items changed.

**Conclusion:**

Please let me know if you require anything further. Thank you.

Sincerely,

Melissa Guffey  
703-518-5000, x3005

Sincerely,  
Melissa Guffey

---

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

## Note To Reviewer

**Created By:**

Melissa Guffey on 01/25/2013 09:27 AM

**Last Edited By:**

Melissa Guffey

**Submitted On:**

01/25/2013 09:29 AM

**Subject:**

Break-out filing from DMND-128803830

**Comments:**

Based on your objection, we have separated our two rate filings. This is the 700 series rate filing which is an upgraded plan from our 600 series rates. If you have any questions/concerns, please give me a call.

Sincerely,

Melissa Guffey  
703-518-5000, x3005

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (700) 2013 rates  
**Project Name/Number:** /

## Post Submission Update Request Processed On 03/04/2013

**Status:** Allowed  
**Created By:** Melissa Guffey  
**Processed By:** Darniece Shirley  
**Comments:**

### Company Rate Information:

Company Name: Dominion Dental Services, Inc.

Field Name	Requested Change	Prior Value
# of Policy Holders Affected for this Program	19	84
Maximum %Change (where required)	5.000%	
Minimum %Change (where required)	5.000%	

SERFF Tracking #:

DMND-128866554

State Tracking #:

Company Tracking #:

121012

State: District of Columbia

Filing Company: Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (700) 2013 rates

Project Name/Number: /

### Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: Increase

Overall Percentage of Last Rate Revision: 4.500%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

### Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Dominion Dental Services, Inc.	4.500%	4.500%	\$4,230	19	\$94,020	5.000%	5.000%

SERFF Tracking #:

DMND-128866554

State Tracking #:

Company Tracking #:

121012

State: District of Columbia

Filing Company: Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (700) 2013 rates

Project Name/Number: /

### Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Select Plan 700-series rates	DC 09GDSC, 09GDSCa1-DC	New		700 series (4.5% rate increase) 2013 rate sheet.pdf

**700 SERIES SELECT PLAN MONTHLY GROUP PREMIUM RATES –  
Effective 7/1/13  
(for states other than Delaware)**

<b>Plan<sup>1</sup></b>	<b>Standard Premium Tier</b>	<b>Standard Rate<sup>2 and 3</sup></b>
<b>703X</b>	Subscriber	\$17.72
	Subscriber + 1 dependent	\$32.76
	Subscriber + 2 or More dependents	\$48.74
<b>705X</b>	Subscriber	\$24.04
	Subscriber + 1 dependent	\$44.50
	Subscriber + 2 or More dependents	\$66.36
<b>707X</b>	Subscriber	\$25.56
	Subscriber + 1 dependent	\$47.16
	Subscriber + 2 or More dependents	\$70.30
<b>709X</b>	Subscriber	\$27.38
	Subscriber + 1 dependent	\$50.64
	Subscriber + 2 or More dependents	\$75.22
<b>708X</b>	Subscriber	\$26.80
	Subscriber + 1 dependent	\$49.64
	Subscriber + 2 or More dependents	\$73.74

<b>700 SERIES SELECT PLAN MONTHLY GROUP PREMIUM RATES – Effective 7/1/13 (Cont'd)</b>		
<b>Rating Tier</b>	<b>Equivalent in Standard Premium Tier</b>	<b>2-Tier Formulas and 4-Tier Formulas</b>
<b>2-Tier Rates</b>	Subscriber	Subscriber
	Subscriber + 1 dependent	N/A
	Subscriber + 2 or More dependents	Subscriber + Family calculated as: (Subscriber + 1 Dependent) .35 + (Subscriber + 2 or more Dependents) .65
<b>4-Tier Rates</b>	Subscriber	Subscriber
	Subscriber + 1 dependent	Subscriber + Spouse
	Subscriber + 2 or More dependents	Subscriber + Family
		Subscriber + Child/ren calculated as: (Subscriber + 1 dependent) .65 + (Subscriber + 2 or more Dependents) .35

<sup>1</sup> “X” plan is offered with specialists care included at the same member copayments, premium rates increase an additional 12% (These plans are indicated by an “S” at the end of the plan number – i.e., 705XS, 707XS, etc.). When the same plan is made available without an office visit copayment (same plan number without the “X” – i.e., 705, 707) premium rates increase 3%. When the same non-“X” plan is offered with specialists care included at the same member copayments except no office visit copayment, premium rates increase an additional 15% (These plans are indicated by an “S” at the end of the plan number – i.e., 705S, 707S, etc.).

<sup>2</sup> Discounts ranging from 1% to 40% may be applied to standard rates based on underwriting criteria including group size, prior dental experience, dependent age limits and employer contribution.

<sup>3</sup> Dependent children are covered under the dental policy until their 26<sup>th</sup> birthday. Upon request by the group policyholder, lower age limits will be provided in the policy with the discounts ranging from 1% to 40% as noted above and higher age limits will be provided in the policy with the following rate adjustment factors (the rate will be multiplied by the factor in the table below):

<b>Dependent Children and Student Adjustments</b>					
<b>Age in School</b>	<b>Dependent Age</b>				
	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>
<b>26</b>	1.000	#N/A	#N/A	#N/A	#N/A
<b>27</b>	1.002	1.007	#N/A	#N/A	#N/A
<b>28</b>	1.005	1.010	1.014	#N/A	#N/A
<b>29</b>	1.007	1.012	1.017	1.021	#N/A
<b>30</b>	1.010	1.014	1.019	1.024	1.029

SERFF Tracking #:

DMND-128866554

State Tracking #:

Company Tracking #:

121012

State: District of Columbia

Filing Company:

Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (700) 2013 rates

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter All Filings		
Comments:	Please see filing description which includes the details of this filing and satisfies the information required in the cover letter.		
		Item Status:	Status Date:
Bypassed - Item:	Certificate of Authority to File		
Bypass Reason:	N/A		
		Item Status:	Status Date:
Satisfied - Item:	Actuarial Memorandum		
Comments:			
Attachment(s):	Actuarial Memorandum Select Plan 700-Series Group - REVISED 1-25-13.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Actuarial Justification		
Comments:	Please see attached Memorandum for the Actuarial Justification provision.		
		Item Status:	Status Date:
Satisfied - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)		
Comments:	Please see attached Actuarial Memorandum for information on the anticipated loss ratio.		
		Item Status:	Status Date:
Satisfied - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)		

**State:** District of Columbia

**Filing Company:** Dominion Dental Services, Inc.

**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental

**Product Name:** Select Plan Series (700) 2013 rates

**Project Name/Number:** /

Comments: We do not have a 5 year rate history for this rate filing as we just became licensed in DC in 2010, making this our 2nd rate filing; however, below is the information since we became licensed in DC. We have referenced the previous rate filings for your information and included the most recent approval as a separate document in this section.

DC loss experience, current 62.384%  
 DC loss experience, 36-mos 60.091%  
 DC loss experience, Lifetime 60.636%

Nationwide loss experience, current: 57.169%  
 Nationwide loss experience, 36-mos 56.872%  
 Nationwide loss experience, Lifetime 56.801%

Attachment(s):  
 Info for Rate Filing (700 Series 4.5% incr) 2013.pdf

		Item Status:	Status Date:
Bypassed - Item:	Rate Summary Worksheet		
Bypass Reason:	n/a		

		Item Status:	Status Date:
Satisfied - Item:	Select Plan 700-Series Supporting Documentation		
Comments:	Previously approved 600-series rate filing.		
Attachment(s):	Previous Rate Filing (Group 600 series (5% rate increase) 2012 rates).pdf		

**Dominion Dental**  
**DENTAL INSURANCE POLICIES**  
**SELECT (DHMO) GROUP PLANS**  
**ACTUARIAL MEMORANDUM**

**Policy Form Numbers:**  
DC 09GDSC and 09GDSCa1-DC

**Scope and purpose**

The purpose of this memorandum is to describe the benefits and document the rates with supporting data, and to certify that this product is in compliance with the applicable laws and regulations of the state. This memorandum is not intended to be used for any other purpose.

**Proposed Effective Date**

We request an effective date of July 1, 2013 for the Select Plan 700-series. Marketing will commence immediately upon approval of this filing.

**Select Plan Benefit Description**

The Select Plan series of benefits are formulated on a capitated delivery model in which Providers are paid primarily through a combination of copayments and capitation. As such, there is very minimal claims or related indemnity liability with these benefits. Capitation levels are calculated on the basis of actual cost of care as compared to usual and customary charges. Rate increases only occur as the cost of dental materials and dental related overhead increases. We have designed eleven basic Select Plans outlined in the table below.

Select Plan 703X - Low Option Group Plan
Select Plan 705X - Medium Option Group Plan
Select Plan 707X - Medium-High Option Group Plan
Select Plan 708X - Medium-High Option Group Plan
Select Plan 709X - High Option Group Plan

**Premium Change Rationale**

The Select Plan 700-series is a refresh of the previously approved Select Plan 600-series. There is a 4.5% rate increase over the Select Plan 600-series. These rates will become effective July 1, 2013 for prospective and renewal quotes. As described in the Anticipated Loss Ratio section of this Memorandum, participating providers receive compensation payments averaging 61% of premium revenue. The rate increases submitted for approval directly correspond to provider service cost increases being requested by network providers. There are no expected changes in utilization patterns associated with the requested

rate change. Upon approval, providers will receive a 4.5% increase to capitation rates for eligible members as they renew.

### **Anticipated Loss Ratio**

The following table shows how premium dollars are distributed in the Select Plans for compensating participating dentists and administration costs.

- 61% Dentist Compensation
- 29% Internal Administrative Costs
- 10% External Commissions
- 0% Profit

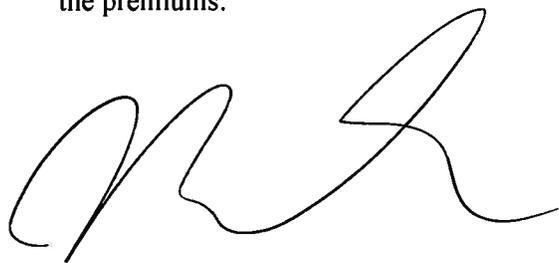
These expense assumptions are based on our actual expected costs. The rates in this filing do not include a provision or load for profit margin, surplus contribution, or surplus level.

### **Reasonableness of Assumptions**

In the actuary's best judgment, the assumptions made in determining these premium rates are reasonable.

### **ACTUARIAL CERTIFICATION**

I, Mark Spitler, am a Fellow 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, FSA, MAAA

Senior Director, Actuarial Services  
Capital BlueCross  
(717) 541-6613

January 22, 2013

5-Year History - Standard Rates  
 (rate sheets from previous filings attached)

	Proposed Rates per this filing	Current Rates filed 11/19/11	Rates filed 3/17/10	Rates Filed 6/4/08	Rates Filed 3/21/06
Plan Series	700	600	600	600	600
Effective Date	7/1/2013	4/1/2012	4/1/2010	4/1/2008	4/1/2006
Increase	4.50%	5%	10%	8%	10%

## Disposition for DMND-127807344

**SERFF Tracking Number:** DMND-127807344 **State:** District of Columbia

**Filing Company:** Dominion Dental Services, Inc. **State Tracking Number:**

**Company Tracking Number:** 11911

**TOI:** H10G Group Health - Dental **Sub-TOI:** H10G.000 Health Dental

**Product Name:** 600 series 5% increase 2012

**Project Name:**

**Disposition Date:** 01/11/2012

**Implementation Date:** 04/01/2012

**Status:** \* APPROVED

**Comments:**

### Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Dominion Dental Services, Inc.	5.000 %	5.000 %	\$ 10215	21	\$ 204306	5.080 %	4.980 %

### Schedule Items

Item Type	Item Name	Item Status	Public Access
Supporting Document	Actuarial Justification		Yes
<i>Supporting Document</i>	<i>Actuarial Justification</i>		<i>Yes</i>

Supporting Document	Transmittal letter	No
<i>Supporting Document</i>	<i>Transmittal letter</i>	<i>Yes</i>
Rate	600 series DHMO rates	Yes
<i>Rate</i>	<i>600 series DHMO rates</i>	<i>Yes</i>
<i>Rate</i>	<i>600 series DHMO rates</i>	<i>Yes</i>

**600 SERIES SELECT PLAN MONTHLY GROUP PREMIUM RATES –  
Effective 4/1/12  
(for states other than Delaware)**

<b>Plan<sup>1</sup></b>	<b>Standard Premium Tier</b>	<b>Standard Rate<sup>2 and 3</sup></b>
<b>603X</b>	Subscriber	\$16.96
	Subscriber + 1 dependent	\$31.34
	Subscriber + 2 or More dependents	\$46.64
<b>605X</b>	Subscriber	\$23.00
	Subscriber + 1 dependent	\$42.58
	Subscriber + 2 or More dependents	\$63.50
<b>607X</b>	Subscriber	\$24.46
	Subscriber + 1 dependent	\$45.12
	Subscriber + 2 or More dependents	\$67.28
<b>609X</b>	Subscriber	\$26.20
	Subscriber + 1 dependent	\$48.46
	Subscriber + 2 or More dependents	\$71.98
<b>608X</b>	Subscriber	\$25.64
	Subscriber + 1 dependent	\$47.50
	Subscriber + 2 or More dependents	\$70.56

<b>600 SERIES SELECT PLAN MONTHLY GROUP PREMIUM RATES – Effective 4/1/12 (Cont'd)</b>		
<b>Rating Tier</b>	<b>Equivalent in Standard Premium Tier</b>	<b>2-Tier Formulas and 4-Tier Formulas</b>
<b>2-Tier Rates</b>	Subscriber	Subscriber
	Subscriber + 1 dependent	N/A
	Subscriber + 2 or More dependents	Subscriber + Family calculated as: (Subscriber + 1 Dependent) .35 + (Subscriber + 2 or more Dependents) .65
<b>4-Tier Rates</b>	Subscriber	Subscriber
	Subscriber + 1 dependent	Subscriber + Spouse
	Subscriber + 2 or More dependents	Subscriber + Family
		Subscriber + Child/ren calculated as: (Subscriber + 1 dependent) .65 + (Subscriber + 2 or more Dependents) .35

<sup>1</sup> “X” plan is offered with specialists care included at the same member copayments, premium rates increase an additional 12% (These plans are indicated by an “S” at the end of the plan number – i.e., 605XS, 607XS, etc.). When the same plan is made available without an office visit copayment (same plan number without the “X” – i.e., 605, 607) premium rates increase 3%. When the same non-“X” plan is offered with specialists care included at the same member copayments except no office visit copayment, premium rates increase an additional 15% (These plans are indicated by an “S” at the end of the plan number – i.e., 605S, 607S, etc.).

<sup>2</sup> Discounts ranging from 1% to 40% may be applied to standard rates based on underwriting criteria including group size, prior dental experience, dependent age limits and employer contribution.

<sup>3</sup> Dependent children are covered under the dental policy until their 26<sup>th</sup> birthday. Upon request by the group policyholder, lower age limits will be provided in the policy with the discounts ranging from 1% to 40% as noted above and higher age limits will be provided in the policy with the following rate adjustment factors (the rate will be multiplied by the factor in the table below):

<b>Dependent Children and Student Adjustments</b>					
<b>Age in School</b>	<b>Dependent Age</b>				
	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>
<b>26</b>	1.000	#N/A	#N/A	#N/A	#N/A
<b>27</b>	1.002	1.007	#N/A	#N/A	#N/A
<b>28</b>	1.005	1.010	1.014	#N/A	#N/A
<b>29</b>	1.007	1.012	1.017	1.021	#N/A
<b>30</b>	1.010	1.014	1.019	1.024	1.029

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (7000) 2013 rates-REVISED  
**Project Name/Number:** /

## Filing at a Glance

Company: Dominion Dental Services, Inc.  
Product Name: Select Plan Series (7000) 2013 rates-REVISED  
State: District of Columbia  
TOI: H10G Group Health - Dental  
Sub-TOI: H10G.000 Health Dental  
Filing Type: Rate  
Date Submitted: 02/18/2013  
SERFF Tr Num: DMND-128901322  
SERFF Status: Closed-APPROVED  
State Tr Num:  
State Status:  
Co Tr Num: 121012  
Co Status:  
Implementation: 04/01/2013  
Date Requested:  
Author(s): Melissa Guffey  
Reviewer(s): Darniece Shirley (primary), Carolyn King  
Disposition Date: 02/26/2013  
Disposition Status: APPROVED  
Implementation Date: 04/01/2013

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** Select Plan Series (7000) 2013 rates-REVISED  
**Project Name/Number:** /

## General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: File & Use	Domicile Status Comments: The filing in Virginia was submitted at the same time as this filing; therefore it is still pending approval.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact: 4.5%
Filing Status Changed: 02/26/2013	Company Status Changed:
State Status Changed:	Deemer Date:
Created By: Melissa Guffey	Submitted By: Melissa Guffey
Corresponding Filing Tracking Number: DMND-127807343 & DMND-128671058	

### Filing Description:

We recently discovered that we inadvertently left out an orthodontics option on our form and rates for the 7000 series Select Plans and therefore need to file this amendment which will replace the previously approved rates (SERFF Tracking #DMND-DMND-128803830). If you have any additional questions or concerns, please do not hesitate to contact me. Thank you.

Sincerely,

Melissa Guffey  
703-518-5000, x3005

## Company and Contact

### Filing Contact Information

Melissa Guffey, Senior Regulatory Analyst	mguffey@dominiondental.com
115 S. Union Street	703-518-5000 [Phone] 3005 [Ext]
Suite 300	703-859-7716 [FAX]
Alexandria, VA 22314	

### Filing Company Information

Dominion Dental Services, Inc.	CoCode: 95657	State of Domicile: Virginia
115 S. Union Street	Group Code: 1230	Company Type: Dental Plan
Suite 300	Group Name: Capital Blue Cross	Organizatoion
Alexandria, VA 22314	FEIN Number: 54-1808292	State ID Number:
(703) 518-5000 ext. 3047[Phone]		

## Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

SERFF Tracking #:

DMND-128901322

State Tracking #:

Company Tracking #:

121012

State:

District of Columbia

Filing Company:

Dominion Dental Services, Inc.

TOI/Sub-TOI:

H10G Group Health - Dental/H10G.000 Health Dental

Product Name:

Select Plan Series (7000) 2013 rates-REVISED

Project Name/Number:

/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Darniece Shirley	02/26/2013	02/26/2013

State: District of Columbia

Filing Company:

Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (7000) 2013 rates-REVISED

Project Name/Number: /

## Disposition

Disposition Date: 02/26/2013

Implementation Date: 04/01/2013

Status: APPROVED

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Dominion Dental Services, Inc.	0.000%	0.000%	\$0	0	\$0	%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter All Filings		Yes
Supporting Document	Certificate of Authority to File		Yes
Supporting Document	Actuarial Memorandum		Yes
Supporting Document	Actuarial Justification		Yes
Supporting Document	District of Columbia and Countrywide Loss Ratio Analysis (P&C)		Yes
Supporting Document	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)		Yes
Supporting Document	Rate Summary Worksheet		Yes
Rate	Select Plan 7000-series rates		Yes

SERFF Tracking #:

DMND-128901322

State Tracking #:

Company Tracking #:

121012

State: District of Columbia

Filing Company: Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (7000) 2013 rates-REVISED

Project Name/Number: /

### Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: %

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

### Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Dominion Dental Services, Inc.	0.000%	0.000%	\$0	0	\$0	%	%

SERFF Tracking #:

DMND-128901322

State Tracking #:

Company Tracking #:

121012

State: District of Columbia

Filing Company: Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (7000) 2013 rates-REVISED

Project Name/Number: /

## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Select Plan 7000-series rates	DC 09GDSC, 09GDSCa1-DC	New		7000 series 2013 rates with Ortho (2-18-13).pdf

**7000 SERIES SELECT (DHMO) PLAN MONTHLY GROUP PREMIUM  
RATES – Effective 4/1/13**

<b>Plan<sup>1</sup></b>	<b>Standard Premium Tier</b>	<b>Standard Rate<sup>2 and 3</sup></b>
<b>7010</b>	Subscriber	\$28.48
	Subscriber + 1 dependent	\$51.78
	Subscriber + 2 or More dependents	\$82.08
<b>7020</b>	Subscriber	\$33.58
	Subscriber + 1 dependent	\$61.10
	Subscriber + 2 or More dependents	\$95.74
<b>7030</b>	Subscriber	\$39.48
	Subscriber + 1 dependent	\$71.80
	Subscriber + 2 or More dependents	\$111.42
<b>7040</b>	Subscriber	\$36.88
	Subscriber + 1 dependent	\$67.08
	Subscriber + 2 or More dependents	\$104.50
<b>7050</b>	Subscriber	\$40.34
	Subscriber + 1 dependent	\$73.36
	Subscriber + 2 or More dependents	\$113.76
<b>7060</b>	Subscriber	\$44.22
	Subscriber + 1 dependent	\$80.36
	Subscriber + 2 or More dependents	\$124.02

Rating Tier	Equivalent in Standard Premium Tier	2-Tier Formulas and 4-Tier Formulas
<b>2-Tier Rates</b>	Subscriber	Subscriber
	Subscriber + 1 dependent	N/A
	Subscriber + 2 or More dependents	Subscriber + Family calculated as: (Subscriber + 1 Dependent) .35 + (Subscriber + 2 or more Dependents) .65
<b>4-Tier Rates</b>	Subscriber	Subscriber
	Subscriber + 1 dependent	Subscriber + Spouse
	Subscriber + 2 or More dependents	Subscriber + Family
		Subscriber + Child/ren calculated as: (Subscriber + 1 dependent) .65 + (Subscriber + 2 or more Dependents) .35

<sup>1</sup> When a plan is made available with a \$5 office visit copayment (Same plan number with "XR") premium rates are divided by 103% [approx 3% decrease]. When a plan is made available with a \$10 office visit copayment (Same plan number with "X") premium rates are divided by 106% [approx 6% decrease].

<sup>2</sup> Discounts ranging from 1% to 40% may be applied to standard rates based on underwriting criteria including group size, prior dental experience, dependent age limits and employer contribution.

<sup>3</sup> Dependent children are covered under the dental policy until their 26<sup>th</sup> birthday. Upon request by the group policyholder, lower age limits will be provided in the policy with the discounts ranging from 1% to 40% as noted above and higher age limits will be provided in the policy with the following rate adjustment factors (the rate will be multiplied by the factor in the table below):

<b>Dependent Children and Student Adjustments</b>					
Age in School	Dependent Age				
	26	27	28	29	30
26	1.000	#N/A	#N/A	#N/A	#N/A
27	1.002	1.007	#N/A	#N/A	#N/A
28	1.005	1.010	1.014	#N/A	#N/A
29	1.007	1.012	1.017	1.021	#N/A
30	1.010	1.014	1.019	1.024	1.029

<sup>4</sup> Upon request by the group policyholder, an additional ortho rider may be purchased with the following rate adjustments:

**2-Tier Rate Structure**

Subscriber **0.00**  
Subscriber + 1 dependent **4.08**

**3-Tier Rate Structure**

Subscriber **0.00**  
Subscriber + 1 dependent **0.86**  
Subscriber + 2 or More dependents **5.54**

**4-Tier Rate Structure**

Subscriber **0.00**  
Subscriber + Spouse **0.00**  
Subscriber + Child(ren) **5.26**  
Subscriber + 2 or More dependents **5.54**

State: District of Columbia

Filing Company: Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: Select Plan Series (7000) 2013 rates-REVISED

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter All Filings		
Comments:	Please see filing description which includes the details of this filing and satisfies the information required in the cover letter.		
		Item Status:	Status Date:
Bypassed - Item:	Certificate of Authority to File		
Bypass Reason:	N/A		
		Item Status:	Status Date:
Satisfied - Item:	Actuarial Memorandum		
Comments:			
Attachment(s):	Actuarial Memorandum Select Plan 7000-Series Group - REVISED 1-25-13.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Actuarial Justification		
Comments:	Please see attached Memorandum for the Actuarial Justification provision.		
		Item Status:	Status Date:
Satisfied - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)		
Comments:	Please see attached Actuarial Memorandum for information on the anticipated loss ratio.		
		Item Status:	Status Date:
Satisfied - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)		
Comments:	We do not have a 5 year rate history for this rate filing as we just became licensed in DC in 2010, making this our 2nd rate filing; however, we have included our rate history based on business in our state of domicile (Virginia). We have referenced the previous rate filings for your information and included the most recent approval as a separate document in this section.		
Attachment(s):			

**SERFF Tracking #:**

DMND-128901322

**State Tracking #:**

**Company Tracking #:**

121012

**State:**

District of Columbia

**Filing Company:**

Dominion Dental Services, Inc.

**TOI/Sub-TOI:**

H10G Group Health - Dental/H10G.000 Health Dental

**Product Name:**

Select Plan Series (7000) 2013 rates-REVISED

**Project Name/Number:**

/

Info for Rate Filing (700 Series 4.5% incr) 2013.pdf

**Item Status:**

**Status Date:**

Bypassed - Item:

Rate Summary Worksheet

Bypass Reason:

N/A

**Dominion Dental**  
**DENTAL INSURANCE POLICIES**  
**SELECT (DHMO) GROUP PLANS**  
**ACTUARIAL MEMORANDUM**

**Policy Form Numbers:**  
DC 09GDSC and 09GDSCa1-DC

**Scope and purpose**

The purpose of this memorandum is to describe the benefits and document the rates with supporting data, and to certify that this product is in compliance with the applicable laws and regulations of the state. This memorandum is not intended to be used for any other purpose.

**Proposed Effective Date**

We request an effective date of April 1, 2013 for the Select Plan 7000-series. Marketing will commence immediately upon approval of this filing.

**Select Plan Benefit Description**

The Select Plan series of benefits are formulated on a capitated delivery model in which Providers are paid primarily through a combination of copayments and capitation. As such, there is very minimal claims or related indemnity liability with these benefits. Capitation levels are calculated on the basis of actual cost of care as compared to usual and customary charges. Rate increases only occur as the cost of dental materials and dental related overhead increases. We have designed eleven basic Select Plans outlined in the table below.

Select Plan 7010 - Low Option Group Plan
Select Plan 7020 - Medium Option Group Plan
Select Plan 7030 - High Option Group Plan
Select Plan 7040 - High Option Group Plan
Select Plan 7050 - High Option Group Plan
Select Plan 7060 - Highest Option Group Plan

**Premium Change Rationale**

The Select Plan 7000 Series is a new line of products. These rates will become effective April 1, 2013. As described in the Anticipated Loss Ratio section of this Memorandum, participating providers receive compensation payments averaging 61% of premium revenue.

**Anticipated Loss Ratio**

The following table shows how premium dollars are distributed in the Select Plans for compensating participating dentists and administration costs.

- 61% Dentist Compensation
- 29% Internal Administrative Costs
- 10% External Commissions
- 0% Profit

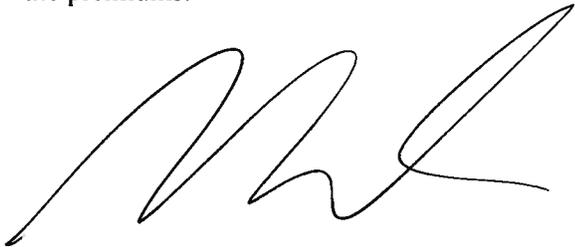
These expense assumptions are based on our actual expected costs. The rates in this filing do not include a provision or load for profit margin, surplus contribution, or surplus level.

#### **Reasonableness of Assumptions**

In the actuary's best judgment, the assumptions made in determining these premium rates are reasonable.

#### **ACTUARIAL CERTIFICATION**

I, Mark Spitler, am a Fellow 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, FSA, MAAA

Senior Director, Actuarial Services  
Capital BlueCross  
(717) 541-6613

January 22, 2013

5-Year History - Standard Rates  
 (rate sheets from previous filings attached)

	Proposed Rates per this filing	Current Rates filed 11/19/11	Rates filed 3/17/10	Rates Filed 6/4/08	Rates Filed 3/21/06
Plan Series	700	600	600	600	600
Effective Date	7/1/2013	4/1/2012	4/1/2010	4/1/2008	4/1/2006
Increase	4.50%	5%	10%	8%	10%

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** DC Shelf Product Rate Filing (Group)  
**Project Name/Number:** /  
 Draft Schedule Item(s) exist

### Filing at a Glance

Company: Dominion Dental Services, Inc.  
 Product Name: DC Shelf Product Rate Filing (Group)  
 State: District of Columbia  
 TOI: H10G Group Health - Dental  
 Sub-TOI: H10G.000 Health Dental  
 Filing Type: Rate  
 Date Submitted: 04/27/2011  
 SERFF Tr Num: DMND-127141233  
 SERFF Status: Closed-APPROVED  
 State Tr Num:  
 State Status:  
 Co Tr Num: DC 42711  
 Co Status:  
 Implementation: 07/01/2011  
 Date Requested:  
 Author(s): Melissa Guffey  
 Reviewer(s): Darniece Shirley (primary)  
 Disposition Date: 07/07/2011  
 Disposition Status: APPROVED  
 Implementation Date: 07/07/2011

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** DC Shelf Product Rate Filing (Group)  
**Project Name/Number:** /  
 Draft Schedule Item(s) exist

### General Information

Project Name: Status of Filing in Domicile: Pending  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: New Submission Group Market Size: Small and Large  
 Group Market Type: Employer Overall Rate Impact:  
 Filing Status Changed: 07/07/2011 Company Status Changed:  
 State Status Changed: Deemer Date:  
 Created By: Melissa Guffey Submitted By: Melissa Guffey  
 Corresponding Filing Tracking Number:

Filing Description:  
 DC Shelf Product Rate Filing (Group)-Actuarial Memorandum Addendum

### Company and Contact

#### Filing Contact Information

Melissa Guffey, Senior Regulatory Analyst mguffey@dominiondental.com  
 115 S. Union Street 703-518-5000 [Phone] 3005 [Ext]  
 Suite 300 703-859-7716 [FAX]  
 Alexandria, VA 22314

#### Filing Company Information

Dominion Dental Services, Inc.	CoCode: 95657	State of Domicile: Virginia
115 S. Union Street	Group Code: 1230	Company Type: Dental Plan
Suite 300	Group Name: Capital Blue Cross	Organizatoion
Alexandria, VA 22314	FEIN Number: 54-1808292	State ID Number:
(703) 518-5000 ext. 3047[Phone]		

### Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:

**State:** District of Columbia

**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental

**Product Name:** DC Shelf Product Rate Filing (Group)

**Project Name/Number:** /

Draft Schedule Item(s) exist

**Filing Company:**

Dominion Dental Services, Inc.

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Darniece Shirley	07/07/2011	07/07/2011

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Darniece Shirley	06/09/2011	06/09/2011

#### Response Letters

Responded By	Created On	Date Submitted
Melissa Guffey	06/21/2011	06/21/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
RE: Status Update	Note To Filer	Darniece Shirley	06/16/2011	06/16/2011
Status update	Note To Reviewer	Melissa Guffey	05/31/2011	06/10/2011

**State:** District of Columbia**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental**Product Name:** DC Shelf Product Rate Filing (Group)**Project Name/Number:** /

Draft Schedule Item(s) exist

**Filing Company:**

Dominion Dental Services, Inc.

## Disposition

Disposition Date: 07/07/2011

Implementation Date: 07/07/2011

Status: APPROVED

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
<b>Supporting Document (revised)</b>	Actuarial Justification		Yes
<b>Supporting Document</b>	Actuarial Justification		Yes
<b>Supporting Document (revised)</b>	Transmittal Letter		No
<b>Supporting Document</b>	Transmittal Letter		Yes

---

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** DC Shelf Product Rate Filing (Group)  
**Project Name/Number:** /  
Draft Schedule Item(s) exist

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/09/2011
Submitted Date	06/09/2011
Respond By Date	06/23/2011

---

Dear Melissa Guffey,

**Introduction:**

Thank you for your recent filing.

**Objection 1**

- Actuarial Justification (Supporting Document)

Comments: Please provide the number of DC policy holders and covered lives, as well as current DC loss experience.

**Objection 2**

- Actuarial Justification (Supporting Document)

Comments: The filing indicates adding three (3) factors to the Miscellaneous factors table (Table ba), however the January 6, 2011 filing shows this table as bb. Please confirm. Also, please clarify the three factors (it appears the filing only addresses the Addition of Posterior Composites factor and the Addition of a factor to remove Preventive and Diagnostic procedures from Annual Maximum) to be added. Please justify the need for these additional factors as it was not clear in the filing.

**Conclusion:**

Sincerely,  
Darniece Shirley

State: District of Columbia

Filing Company:

Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: DC Shelf Product Rate Filing (Group)

Project Name/Number: /

Draft Schedule Item(s) exist

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/21/2011
Submitted Date	06/21/2011

Dear Darniece Shirley,

### Introduction:

Attached are the responses to your objections.

### Response 1

#### Comments:

Please see attached addendum and workbook.

### Related Objection 1

Applies To:

- Actuarial Justification (Supporting Document)

Comments: Please provide the number of DC policy holders and covered lives, as well as current DC loss experience.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied - Item:	Actuarial Justification
Comments:	
Attachment(s):	
Actuarial Memorandum Addendum - DC - 4-26-11.pdf	
Actuarial Memorandum Addendum - DC- 6-21-11 - first objection response.pdf	
Data for DC- first objection response for addendum 6-21-11.xls	
<i>Previous Version</i>	
Satisfied - Item:	Actuarial Justification
Comments:	
Attachment(s):	
Actuarial Memorandum Addendum - DC - 4-26-11.pdf	

No Form Schedule items changed.

**State:** District of Columbia

**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental

**Product Name:** DC Shelf Product Rate Filing (Group)

**Project Name/Number:** /

Draft Schedule Item(s) exist

No Rate/Rule Schedule items changed.

**Filing Company:**

Dominion Dental Services, Inc.

## Response 2

### Comments:

Please see attached addendum and workbook.

## Related Objection 2

Applies To:

- Actuarial Justification (Supporting Document)

**Comments:** The filing indicates adding three (3) factors to the Miscellaneous factors table (Table ba), however the January 6, 2011 filing shows this table as bb. Please confirm. Also, please clarify the three factors (it appears the filing only addresses the Addition of Posterior Composites factor and the Addition of a factor to remove Preventive and Diagnostic procedures from Annual Maximum) to be added. Please justify the need for these additional factors as it was not clear in the filing.

## Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Justification
Comments:	
Attachment(s):	
Actuarial Memorandum Addendum - DC - 4-26-11.pdf Actuarial Memorandum Addendum - DC- 6-21-11 - first objection response.pdf Data for DC- first objection response for addendum 6-21-11.xls	
<i>Previous Version</i>	
Satisfied - Item:	Actuarial Justification
Comments:	
Attachment(s):	
Actuarial Memorandum Addendum - DC - 4-26-11.pdf	

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Conclusion:

Please let me know if you require anything further. Thank you.

Sincerely,

Melissa Guffey

---

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** DC Shelf Product Rate Filing (Group)  
**Project Name/Number:** /  
Draft Schedule Item(s) exist

## Note To Filer

**Created By:**

Darniece Shirley on 06/16/2011 01:50 PM

**Last Edited By:**

Darniece Shirley

**Submitted On:**

06/16/2011 01:50 PM

**Subject:**

RE: Status Update

**Comments:**

With respects to Health Insurance, the District is a prior approval jurisdiction.

---

**State:** District of Columbia **Filing Company:** Dominion Dental Services, Inc.  
**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental  
**Product Name:** DC Shelf Product Rate Filing (Group)  
**Project Name/Number:** /  
Draft Schedule Item(s) exist

## Note To Reviewer

**Created By:**

Melissa Guffey on 05/31/2011 06:47 AM

**Last Edited By:**

Melissa Guffey

**Submitted On:**

06/10/2011 07:21 AM

**Subject:**

Status update

**Comments:**

We were under the impression that DC had a deemer date of 30 days to give an approval or objection. Since we are new to filing in DC is this the case? If so, why did this take longer than 30 days to receive a response? Thank you for your assistance.

Sincerely,

Melissa Guffey

SERFF Tracking #:

DMND-127141233

State Tracking #:

Company Tracking #:

DC 42711

State: District of Columbia

Filing Company: Dominion Dental Services, Inc.

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health Dental

Product Name: DC Shelf Product Rate Filing (Group)

Project Name/Number: /

Draft Schedule Item(s) exist

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Actuarial Justification		
Comments:			
Attachment(s):			
Actuarial Memorandum Addendum - DC - 4-26-11.pdf			
Actuarial Memorandum Addendum - DC- 6-21-11 - first objection response.pdf			
Data for DC- first objection response for addendum 6-21-11.xls			

		Item Status:	Status Date:
Satisfied - Item:	Transmittal Letter		
Comments:			
Attachment(s):			
Transmittal Letter 4-26-11.pdf			

SERFF Tracking #:

DMND-127141233

State Tracking #:

Company Tracking #:

DC 42711

---

State:

District of Columbia

Filing Company:

Dominion Dental Services, Inc.

TOI/Sub-TOI:

H10G Group Health - Dental/H10G.000 Health Dental

Product Name:

DC Shelf Product Rate Filing (Group)

Project Name/Number:

/

Draft Schedule Item(s) exist

**Attachment Data for DC- first objection response for addendum 6-21-11.xls is not a PDF document and cannot be reproduced here.**

**Dominion Dental**  
**GROUP DENTAL INSURANCE POLICY**  
**ACTUARIAL MEMORANDUM**  
**ADDENDUM**

Policy Form Number DC 09GDSC and 09GDSCa1-DC

**Scope and Purpose**

The purpose of this addendum to the previously filed actuarial memorandum is to describe the updates to benefits and assumptions for the previously filed Group Dental 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.

**Background**

In January 2011 the original pricing methodology was filed. This methodology takes a starting claims cost and adjusts it based on several factors determined by the requested benefit configuration. This filing seeks to add three new factors to the Miscellaneous factors table (Table ba), to remove the currently approved factors for Employer Paid Percentage (Table k), and to increase the flexibility of various other approved tables by adding more benefit variations. Enclosed is a list of requested factor tables and the other currently approved factor tables.

**Description of Updates**

**1) Addition of Posterior Composites factor**

A factor of 1.01 will be applied to add coverage for Posterior Composites.

**2) Addition of a factor to remove Preventive and Diagnostic procedures from Annual Maximum**

A factor of 1.0075 will be applied to remove Preventive and Diagnostic procedures from the annual maximum. This factor will not apply if there is no annual maximum.

**3) Updated Employer Paid Percentage Factors**

We seek to remove table k entirely and to simply use table b to adjust the starting claims cost for various levels of employer contribution.

Currently approved factors:

<b>k) Employer Paid Percentage</b>	
<u>%</u>	<u>Factor</u>
0%	1.10
under 40%	1.10
40-49%	1.06
50-59%	1.04
60-74%	1.02
75% or higher	1.00

**4) In Network Coinsurance Factors:**

For Class 2 Basic, add:

95% option: 1.06

100% option: 1.08

For Class 3 Major, add:

75% option: 1.11

80% option: 1.13

For Class 4 Ortho, add 80% option.

**5) Out of Network Coinsurance Factors:**

For Class 2 Basic, add:

95% option: 1.0249

100% option: 1.0332

For Class 3 Major, add:

75% option: 1.0415

80% option: 1.0498

For Class 4 Ortho, add separate options from 25% to 80%.

For Ortho, assume 60% in network, 40% out of network and assume out of network cost is 120% of in network cost. Starting claim cost: a) per adult for 50% benefit is \$1.39 in and \$1.67 out (\$1.50 total @ 60/40) and b) per child for 50% benefit is \$2.78 in and \$3.33 out (\$3 total @ 60/40).

**6) Waiting Periods**

For Class 4 Ortho, add the following factors:

0: 1.25

6: 1.13

12: 1.00

15: .98

18: .95

24: .90

**7) Participation**

Voluntary factor changed from 1.33 to 1.13.

**8) Two-year rate guarantee**

Add a factor of 1.039 for a two year rate guarantee.

**9) Industry Factors**

Add the following:

Schools, municipalities, government: 1.10.

All others: 1.00.

**Anticipated Loss Ratio**

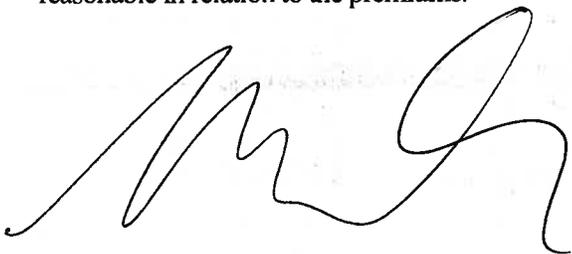
The anticipated loss ratio for this Policy and Addendum will be 60% or greater in all durations.

**Proposed Effective Date**

It is requested that this Addendum become effective July 1, 2011 or 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

April 26, 2011

## Factor Tables

a) Industry	Factor
Schools, Municipalities, Gov't **	1.100
All Others **	1.000

b) Participation Adjustments	
Participation	Factor
Employer Paid	1.00
Voluntary**	1.13
Association	1.28

c) In-Network Factors							
Class 1		Class 2		Class 3		Class 4	
75%	0.91	25%	0.72	0%	0.80	No Ortho	N/A
80%	0.93	30%	0.75	5%	0.81	25%	1
85%	0.95	35%	0.78	10%	0.82	30%	1
90%	0.97	40%	0.81	15%	0.83	35%	1
95%	0.99	45%	0.84	20%	0.84	40%	1
100%	1.00	50%	0.87	25%	0.85	45%	1
		55%	0.90	30%	0.88	50%	1
		60%	0.92	35%	0.91	55%	1
		65%	0.94	40%	0.94	60%	1
		70%	0.96	45%	0.97	65%	1
		75%	0.98	50%	1.00	70%	1
		80%	1.00	55%	1.03	75%	1
		85%	1.02	60%	1.05	80%**	1
		90%	1.04	65%	1.07		
		95%**	1.06	70%	1.09		
		100%**	1.08	75%**	1.11		
				80%**	1.13		

d) Out-f-Network Factors							
Class 1		Class 2		Class 3		Class 4**	
0%	0.8340	0%	0.8672	0%	0.9170	No Ortho	N/A
50%	0.9170	15%	0.8921	5%	0.9253	25%	1
55%	0.9253	20%	0.9004	10%	0.9336	30%	1
60%	0.9336	25%	0.9087	15%	0.9419	35%	1
65%	0.9419	30%	0.9170	20%	0.9502	40%	1
70%	0.9502	35%	0.9253	25%	0.9585	45%	1
75%	0.9585	40%	0.9336	30%	0.9668	50%	1
80%	0.9668	45%	0.9419	35%	0.9751	55%	1
85%	0.9751	50%	0.9502	40%	0.9834	60%	1
90%	0.9834	55%	0.9585	45%	0.9917	65%	1
95%	0.9917	60%	0.9668	50%	1.0000	70%	1
100%	1.0000	65%	0.9751	55%	1.0083	75%	1
		70%	0.9834	60%	1.0166	80%	1
		75%	0.9917	65%	1.0249		
		80%	1.0000	70%	1.0332		
		85%	1.0083	75%**	1.0415		
		90%	1.0166	80%**	1.0498		
		95%**	1.0249				
		100%**	1.0332				

**e) Area Factors**

<u>ST</u>	<u>ZIP3</u>	<u>Factor</u>	<u>ST</u>	<u>ZIP3</u>	<u>Factor</u>	<u>ST</u>	<u>ZIP3</u>	<u>Factor</u>
PA	150	0.75	PA	182	0.90	MD	215	0.85
PA	151	0.80	PA	183	0.90	MD	216	0.85
PA	152	0.80	PA	184	0.90	MD	217	0.85
PA	153	0.80	PA	185	0.90	MD	218	0.85
PA	154	0.80	PA	186	0.90	MD	219	0.85
PA	155	0.80	PA	187	0.90	VA	201	1.00
PA	156	0.80	PA	188	0.90	VA	220	0.95
PA	157	0.80	PA	189	0.95	VA	221	0.95
PA	158	0.80	PA	190	0.95	VA	222	1.00
PA	159	0.80	PA	191	0.95	VA	223	1.00
PA	160	0.80	PA	192	0.95	VA	224	0.90
PA	161	0.90	PA	193	0.95	VA	225	0.90
PA	162	0.85	PA	194	0.95	VA	226	0.90
PA	163	0.85	PA	195	0.90	VA	227	0.90
PA	164	0.85	PA	196	0.95	VA	228	0.85
PA	165	0.85	DE	197	1.05	VA	229	0.85
PA	166	0.85	DE	198	1.05	VA	230	0.85
PA	167	0.85	DE	199	1.05	VA	231	0.85
PA	168	0.85	DC	200	1.05	VA	232	0.85
PA	169	0.85	DC	202	1.05	VA	233	0.95
PA	170	0.90	DC	203	1.05	VA	234	0.95
PA	171	0.90	DC	204	1.05	VA	235	0.95
PA	172	0.85	DC	205	1.05	VA	236	0.95
PA	173	0.85	DC	569	1.05	VA	237	0.95
PA	174	0.85	MD	206	0.85	VA	238	0.85
PA	175	0.85	MD	207	0.95	VA	239	0.85
PA	176	0.90	MD	208	1.00	VA	240	0.85
PA	177	0.90	MD	209	1.00	VA	241	0.85
PA	178	0.90	MD	210	0.95	VA	242	0.85
PA	179	0.90	MD	211	0.95	VA	243	0.85
PA	180	0.90	MD	212	0.95	VA	244	0.85
PA	181	0.90	MD	214	0.95	VA	245	0.85
						VA	246	0.85

**f) Dependent Children and Student Adjustments**

Age in School	Dependent Age											
	19	20	21	22	23	24	25	26	27	28	29	30
19	0.975	#N/A										
20	0.976	0.977	#N/A									
21	0.977	0.980	0.982	#N/A								
22	0.978	0.981	0.983	0.985	#N/A							
23	0.980	0.982	0.984	0.987	0.989	#N/A						
24	0.981	0.983	0.985	0.988	0.990	0.993	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
25	0.982	0.984	0.987	0.989	0.991	0.993	0.996	#N/A	#N/A	#N/A	#N/A	#N/A
26	0.983	0.986	0.988	0.990	0.993	0.995	0.998	1.000	#N/A	#N/A	#N/A	#N/A
27	0.984	0.987	0.989	0.992	0.994	0.996	0.999	1.002	1.007	#N/A	#N/A	#N/A
28	0.986	0.988	0.990	0.993	0.995	0.998	1.000	1.005	1.010	1.014	#N/A	#N/A
29	0.987	0.989	0.992	0.994	0.996	0.999	1.002	1.007	1.012	1.017	1.021	#N/A
30	0.988	0.990	0.993	0.995	0.998	1.000	1.005	1.010	1.014	1.019	1.024	1.029

**g) Annual Maximums**

<u>Amount</u>	<u>Factor</u>
\$500	0.80
\$750	0.90
\$1,000	1.00
\$1,250	1.06
\$1,500	1.10
\$1,750	1.13
\$2,000	1.15
\$2,500	1.35
\$3,000	1.55
\$4,000	2.00
Unlimited	2.50

<b>h) Waiting Period</b>		
	<b>Waiting Period Months</b>	<b>Factor</b>
<b>Type 1 - Prevent</b>	0	1.00
	1	0.99
	3	0.96
	6	0.94
<b>Type 2 - Basic</b>	0	1.03
	3	1.00
	6	0.97
<b>Type 3 - Major</b>	0	1.15
	6	1.05
	12	1.00
	15	0.98
	18	0.95
	24	0.90
<b>Type 4 - Ortho**</b>	0	1.25
	6	1.13
	12	1.00
	15	0.98
	18	0.95
	24	0.90

<b>i) Quarter Factors</b>									
<b>Year\Quarter:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>Year\Quarter:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>2009</b>	1.00	1.02	1.04	1.05	<b>2025</b>	2.12	2.14	2.16	2.17
<b>2010</b>	1.07	1.09	1.11	1.12	<b>2026</b>	2.19	2.21	2.23	2.24
<b>2011</b>	1.14	1.16	1.18	1.19	<b>2027</b>	2.26	2.28	2.30	2.31
<b>2012</b>	1.21	1.23	1.25	1.26	<b>2028</b>	2.33	2.35	2.37	2.38
<b>2013</b>	1.28	1.30	1.32	1.33	<b>2029</b>	2.40	2.42	2.44	2.45
<b>2014</b>	1.35	1.37	1.39	1.40	<b>2030</b>	2.47	2.49	2.51	2.52
<b>2015</b>	1.42	1.44	1.46	1.47	<b>2031</b>	2.54	2.56	2.58	2.59
<b>2016</b>	1.49	1.51	1.53	1.54	<b>2032</b>	2.61	2.63	2.65	2.66
<b>2017</b>	1.56	1.58	1.60	1.61	<b>2033</b>	2.68	2.70	2.72	2.73
<b>2018</b>	1.63	1.65	1.67	1.68	<b>2034</b>	2.75	2.77	2.79	2.80
<b>2019</b>	1.70	1.72	1.74	1.75	<b>2035</b>	2.82	2.84	2.86	2.87
<b>2020</b>	1.77	1.79	1.81	1.82	<b>2036</b>	2.89	2.91	2.93	2.94
<b>2021</b>	1.84	1.86	1.88	1.89	<b>2037</b>	2.96	2.98	3.00	3.01
<b>2022</b>	1.91	1.93	1.95	1.96	<b>2038</b>	3.03	3.05	3.07	3.08
<b>2023</b>	1.98	2.00	2.02	2.03	<b>2039</b>	3.10	3.12	3.14	3.15
<b>2024</b>	2.05	2.07	2.09	2.10	<b>2040</b>	3.17	3.19	3.21	3.22

Remove this table and re-letter remaining tables.

<b>j) Group Size</b>	
<b>Count</b>	<b>Factor</b>
under 10	1.1
10-50	1.0
51-100	0.98
101-500	0.95
501-1000	0.92
1000+	0.85

<b>Employer Paid Percentage</b>	
<b>%</b>	<b>Factor</b>
0%	1.10
under 40%	1.10
40-49%	1.06
50-59%	1.04
60-74%	1.02
75% or higher	1.00

<b>k) Implants</b>	
<b>Ann Max</b>	<b>Factor</b>
\$500	1.00
\$750	1.01
\$1,000	1.02
\$1,250	1.02
\$1,500	1.02
\$1,750	1.05
\$2,000	1.10
\$2,500	1.15
\$3,000	1.20
\$4,000	1.25
Unlimited	1.25

<b>l) Out of Network Percentile</b>	
<b>Percentile</b>	<b>Factor</b>
<i>PPO (45<sup>th</sup>)</i>	<i>0.8000</i>
35 <sup>th</sup>	0.7600
40 <sup>th</sup>	0.7800
45 <sup>th</sup>	0.8000
50 <sup>th</sup>	0.8200
55 <sup>th</sup>	0.8500
60 <sup>th</sup>	0.8800
65 <sup>th</sup>	0.9100
70 <sup>th</sup>	0.9400
75 <sup>th</sup>	0.9700
80 <sup>th</sup>	1.00000
85 <sup>th</sup>	1.05667
90 <sup>th</sup>	1.11333
95 <sup>th</sup>	1.17000

m) Tier Factors						
Tier	Choice Factor					
	2	<u>Single</u> 1	<u>Family</u> 2.5			
3	<u>Single</u> 1	<u>EE+1</u> 1.871	<u>Family</u> 2.92			
4	<u>Single</u> 1	<u>H/W</u> 1.95	<u>EE+child(ren)</u> 2.03	<u>Family</u> 3		
5	<u>Single</u> 1	<u>H/W</u> 1.95	<u>EE+child</u> 1.65	<u>EE+children</u> 2.4	<u>Family</u> 3	
6	<u>Single</u> 1	<u>H/W</u> 1.95	<u>EE+child</u> 1.65	<u>EE+children</u> 2.4	<u>H/W+child</u> 2.6	<u>Family</u> 3.3

n) State Tax	
State	Premium Tax
MD	2.00%
DE	0.00%
VA	2.25%
PA	0.00%
DC	2.00%

o) Other Expense Items			
Level Commission Options 0% to 20%	Per Subscriber Flat Commission Options \$0.00 to \$6.00	Administrative Load Options	
		Amount by % of Premium 0% to 18%	\$ Amt per tier (Subscriber) \$0.00 to \$9.00

p) Graduated Commission	
Graduated Commission	Equivalent Level Commission
0%	0.00%
22% 1st yr / 1% subsequent yrs	6.25%
21% 1st yr / 2% subsequent yrs	6.75%
20% 1st yr / 5% subsequent yrs	8.75%
19% 1st yr / 5% subsequent yrs	8.50%
18% 1st yr / 5% subsequent yrs	8.25%
17% 1st yr / 5% subsequent yrs	8.00%
16% 1st yr / 6% subsequent yrs	8.50%
15% 1st yr / 6% subsequent yrs	8.25%
14% 1st yr / 6% subsequent yrs	8.00%
13% 1st yr / 7% subsequent yrs	8.50%
12% 1st yr / 7% subsequent yrs	8.25%

q) Endo Factors		
No Coverage*	In Class II	In Class III
0.90	$3 * (\text{Class II In Network Coins} - \text{Class III In Network Coins}) / 30$	1

r) Perio Factors		
No Coverage*	In Class II	In Class III
0.93	$3 * (\text{Class II In Network Coins} - \text{Class III In Network Coins}) / 30$	1

s) Oral Surgery Factors		
No Coverage*	In Class II	In Class III
0.95	$3 * (\text{Class II In Network Coins} - \text{Class III In Network Coins}) / 30$	1

\* Note: The No Coverage factor will be 1.00 if the Class III In Network Coinsurance is less than 50%.

Deductible Waived for Preventive?	t1) Reduction of In Network Amount	t2) Reduction of Out Network Amount
Yes	$.027 * .65 * \text{In Network Ann Deductible}$	$.018 * .65 * \text{Out of Network Ann Deductible}$
No	$.027 * \text{In Network Ann Deductible}$	$.018 * \text{Out of Network Ann Deductible}$

u) Additional Perio Benefit with Diabetes	
10% Additional Perio Benefit with Diabetes?	Factor
YES:	$1 + 0.01 / (\text{Selected, Class II or Class III, In Network Coins})$
NO:	1

v) Bitewing X-rays	
	Factor
Not Covered:	.96
Covered Under Class I:	1
Covered Under Class II:	$1 + (\text{Class II In Network Coins} - \text{Class I In Network Coins}) / 3$

w) Other X-rays	
	Factor
Not Covered:	.98
Covered Under Class I:	1
Covered Under Class II:	$1 + .06 * (\text{Class II In Network Coins} - \text{Class I In Network Coins}) / 3$

x) Stand Alone or Dual Option	Factor
Stand Alone (PPO)	1
Dual Option	0.93

y) Parents	Factor
Covered:	1.1
Not Covered:	1

z) Sealants	
	Factor
Not Covered:	0.99
Covered Under Class I:	1
Covered Under Class II:	$1 + .01 * (\text{Class II In Network Coins} - \text{Class I In Network Coins}) / 3$

ba) Miscellaneous Factors								
	Extra Cleaning for Pregnant Women	Extra Cleaning for Diabetic	Cancer Screenings	Prior Dental	Rollover of Annual Plan Benefits	Two Year Rate Guarantee**	Posterior Composites**	Remove P&D from Annual Max**
YES:	1.0125	1.0125	1.03	0.98	1.03	1.039	1.01	1.0075
NO:	1	1	1	1	1	1	1	1

bb) Ortho Premium	
Adult:	$1.5 * \text{Adult Ortho Coins} / 0.5 * \text{Adult Ortho Annual Max} / 1000$
Child:	$3 * \text{Child Ortho Coins} / 0.5 * \text{Child Ortho Annual Max} / 1000$

bc) In Network Coinsurance Factor (see Table c above)	
All Products:	$\text{Class 1 Out-of-Network Factor for Class 1 Coins} * \text{Class 2 Out-of-Network Factor for Class 2 Coins} * \text{Class 3 Out-of-Network Factor for Class 3 Coins}$

bd) Out of Network Coinsurance Factor (see Table d above)	
"EPO - No Out of Network" Product:	$\text{Class 1 Out-of-Network Factor for 0\% Coins} * \text{Class 2 Out-of-Network Factor for 0\% Coins} * \text{Class 3 Out-of-Network Factor for 0\% Coins}$
All Other Products:	$\text{Class 1 Out-of-Network Factor for Class 1 Coins} * \text{Class 2 Out-of-Network Factor for Class 2 Coins} * \text{Class 3 Out-of-Network Factor for Class 3 Coins}$

\*\*New factors

**Dominion Dental**  
**GROUP DENTAL INSURANCE POLICY**  
**ACTUARIAL MEMORANDUM**  
**ADDENDUM - First Objection Response**  
Policy Form Number DC 09GDSC and 09GDSCa1-DC

To whom it may concern,

Thank you for your response and inquiries regarding Dominion’s filing from April 2011. We thank you for your continued review and hope that this letter will fully respond to all questions and concerns related in your 6/9/2011 objection letter.

Please see the table below with data relating to your first objection:

“Please provide the number of DC policy holders and covered lives, as well as current DC loss experience.”

Month	Total				District of Columbia			
	Contracts	Members	Premium	Incurred Claims	Contracts	Members	Premium	Incurred Claims
201001	11,876	22,766	528,119	395,724	193	265	4,701	1,954
201002	12,390	23,708	552,969	349,897	210	283	5,062	1,006
201003	12,585	24,040	560,630	420,975	211	288	5,188	1,072
201004	12,826	24,460	572,448	426,472	214	292	5,340	1,705
201005	12,905	24,475	571,480	371,209	217	294	5,288	2,652
201006	12,907	24,498	571,574	410,220	220	299	5,393	1,421
201007	15,812	30,941	666,076	396,652	275	388	6,618	1,938
201008	13,133	24,795	583,566	422,545	220	303	5,254	3,473
201009	13,722	25,784	613,042	315,910	239	327	5,987	2,822
201010	14,261	26,655	632,151	392,736	265	357	6,205	2,301
201011	13,989	26,162	620,508	393,904	261	349	6,102	2,724
201012	14,145	26,509	629,139	405,335	266	358	6,450	2,176
201101	14,987	28,061	675,747	416,571	281	380	7,407	1,900
201102	14,901	27,483	646,333	444,136	271	358	7,042	2,740
201103	15,434	28,470	670,659	480,992	266	351	6,934	3,898
201104	15,390	28,401	668,945	389,831	278	368	7,384	4,406
201105	15,242	28,061	658,111	290,410	280	369	7,353	1,731

Included are Dominion’s total contracts, members, premium and incurred claims as well as the same information for just the D.C. area. As you can see D.C. currently represents a very small, non-representative sampling of our total population. The incurred claims numbers represent claims incurred in that month and paid any time; these are claims that have actually been paid and are not completed.

Regarding your second objection:

“The filing indicates adding three (3) factors to the Miscellaneous factors table (Table ba), however the January 6, 2011 filing shows this table as bb. Please confirm. Also, please clarify the three factors (it appears the filing only addresses the Addition of Posterior Composites factor and the Addition of a factor to remove Preventive and Diagnostic procedures from Annual Maximum) to be added. Please justify the need for these additional factors as it was not clear in the filing.”

You are correct that, in the initial filing, the Miscellaneous factors table was labeled bb. This filing seeks to remove table k and, after re-lettering the remaining tables, table bb would be renamed ba. This filing seeks to add factors to the Miscellaneous factors table for Posterior Composites, removal of Preventive and Diagnostic procedures from Annual Max, and a Two Year Rate Guarantee. These benefits are not currently being offered by Dominion. In researching the marketplace, we feel that being able to offer these benefits to our customers improves the quality of our product offerings. In order to offer these benefits, pricing needed to be determined.

The factor for adding coverage for Posterior Composites comes from actual claims paid data for procedure codes D2391-D2394 (the codes associated with posterior composites). Dominion's claims experience shows that posterior composites are worth approximately \$0.51 per member per month. This represents approximately 3% of the base PMPM level ( $0.51/16.55=0.0308$ ). Due to the relatively small amount of actual claims and the impact of cost-sharing we felt that 1% was a much more marketable and fair increase. The table below summarizes the claims experience:

Incur Year	Proc Code	Service Count	Paid Amount	Cost/Svc	Member Months	Utilization per Member	Cost per Member
2010	D2391	2,290	36,793	16.07	302,132	0.0076	0.12
2010	D2392	2,446	48,315	19.75	302,132	0.0081	0.16
2010	D2393	1,008	59,656	59.18	302,132	0.0033	0.20
2010	D2394	274	8,594	31.37	302,132	0.0009	0.03
2010	Total	6,018	153,359	25.48	302,132	0.0199	<b>0.51</b>

The factor for removing Diagnostic and Preventive services from the annual max was more difficult to determine due to the complexity of claims probability distributions. To determine this factor, I chose to run 70 different plan designs through a consultant relativity model built from the Milliman Dental Guidelines. The factors from the model ranged from 0.1% to 6.9% with a large concentration in the 0.68% to 0.84% range for some of the more common plan designs. Because of this we felt that 0.75% was a reasonable and fair level to set this factor. Included in addition to this response letter is a workbook containing the results from the consultant model.

The factor for a two year rate guarantee is an additional six months of trend. A group's rate is trended to the mid-point of its rating period and the mid-point of a two year contract period is six months after the mid-point of a one year contract period.

Please feel free to contact me at (717) 541 – 6715 (or via e-mail at Terence.Smith@capbluecross.com) if you have any further questions regarding this filing. It is my intent to work closely with you and the Department to expedite this filing and bring this filing to closure as quickly as possible. Thank you for your assistance in this matter.

Sincerely,

Terence Smith  
Associate Actuary  
Capital BlueCross



April 26, 2011

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

Dominion Dental Services, Inc. (DDS) - NAIC #95657– Submission for Approval of Rates

Dear Ms. Fontaine:

Enclosed please find our Access PPO Plan Rate Actuarial Memorandum Addendum for group coverage. These rates correspond to form numbers DC 09GDSC and 09GDSCa1-DC which were approved on January 11, 2011. These are the rates provided to the group for each individual enrolled in the plan and will be effective July 1, 2011.

Our programs are sold to large and small employer groups, associations, trade unions, fraternal organizations, and individuals.

Please do not hesitate to contact me at (703) 518-5000, ext. 3047 or Melissa Guffey at ext. 3005 if you need any further information.

Sincerely,

A handwritten signature in black ink that reads "Kara Greenhouse". The signature is fluid and cursive, with a long horizontal flourish at the end.

Kara Greenhouse  
Vice President of Accounting and Compliance

Enclosures

**State:** District of Columbia**Filing Company:**

Dominion Dental Services, Inc.

**TOI/Sub-TOI:** H10G Group Health - Dental/H10G.000 Health Dental**Product Name:** DC Shelf Product Rate Filing (Group)**Project Name/Number:** /

Draft Schedule Item(s) exist

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/26/2011		Supporting Document	Transmittal Letter	06/21/2011	Transmittal Letter 4-26-11.pdf
04/26/2011		Supporting Document	Actuarial Justification	06/21/2011	Actuarial Memorandum Addendum - DC - 4-26-11.pdf