DOMINION NATIONAL | DENTAL

Group Certificate of Coverage
ePPO Plan

LIMITED BENEFIT PLEASE READ CAREFULLY

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

The address of the principal administrative office of Plan is: Dominion National, 251 18th Street S., Suite 900, Arlington, VA 22202. The telephone number is (703) 518-5000.

Part I. DEFINITIONS

A. **Annual Deductible** shall mean the amount set forth in the Coverage Schedule which each Member must pay each Benefit Year or Calendar Year before Benefits will be paid by the Plan.

B. **Annual Maximum** shall mean the total amount of Benefits set forth in the Coverage Schedule that will be paid to the Member in a Benefit Year or Calendar Year.

C. **Civil Union** shall mean a same-sex relationship similar like marriage that is recognized by law.

D. **Copayment** shall mean the dollar amount listed in the attached Description of Benefits and Member Copayments that the Subscriber is required to pay when a service is rendered.

E. **Dependent** shall mean lawful spouse, through marriage or civil union, of Subscriber and/or unmarried natural, step or adopted children, or children under the Subscriber's legal guardianship, from and after birth up to his/her 26th birthday. Dependent coverage may include a Domestic Partner of Subscriber and/or children of a Civil Union or 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. A Dependent's coverage under this Certificate will terminate at the end of the Calendar Year (December 31st) during which the Dependent turns 26 years of age.

F. **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 to a same or opposite sex adult or in a domestic partnership with another individual, who resides with the covered person and has registered in a state or local domestic partner registry with a covered person.

G. **Group** shall mean the organization or employing unit with which the Subscriber is associated and which has executed the Group Dental Service Contract.

H. **Member** shall mean any individual Subscriber or eligible family Dependent entitled to receive services by reason of the Contract.

Dominion National
251 18th Street S.
Suite 900
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(703) 518-5338
Toll Free (888) 518-5338

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

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

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 insured.

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

Part II. EFFECTIVE DATE OF BENEFITS

When the Group provides its annual open enrollment period, it will begin at least thirty (30) days prior to the 1st day of the contract year. The open enrollment period will extend for a minimum of thirty (30) days. During the annual open enrollment period a Member may enroll, discontinue, or change enrollment in this dental plan offered by the Group. The Group will let the Member know when the open enrollment period begins and ends. Member's effective date of coverage will be indicated on communications provided by Dominion, which will be sent either electronically or via regular mail.

Part III. TERMINATION OR CANCELLATION

Benefits shall cease upon the earliest of the following events:

A. Termination by Group:

1. If the Group terminates its contract with the Plan for any reason, all eligible Member's enrollment in the Plan ends on the same date that the Group terminates its contract. In the event of termination or upon receipt of notice of termination from the Plan, Group shall provide written notice to the Subscriber no later than fifteen (15) days after receipt of the notice of termination.

B. Termination by Plan:

1. Member is entitled to coverage only for the period for which the Plan has received the appropriate Premium from the Group. If the Group fails to pay the appropriate Premiums, the Plan will terminate the Members under the Plan. Group shall provide written notice to the Subscriber no later than fifteen (15) days after receipt of the notice of termination.
2. Upon the date of Dependents attaining the age of 26 or marriage prior to that date (Subject to Part I. B.).
3. If after reasonable efforts to establish and maintain a satisfactory dentist-patient relationship, the Participating Dentist is unable to do so, the Plan reserves the right to transfer the Subscriber and Dependents to a second and then third Participating Dentist of their choice. If the third Participating Dentist is also unable to establish a satisfactory dentist-patient relationship, the Plan reserves the right to terminate the membership of said Subscriber and Dependents. Termination shall be effective on the last day of the month after 31 days of which termination notice occurs. In case of termination by the Plan, and if services have been rendered, no refund will be given to Subscriber.
4. Upon violation of the terms of the Group contract, fraud or deception in the use of services Coverage will be canceled after the 31st day after written notice is mailed to the Subscriber.

PART IV. EXTENSION OF BENEFITS:

Upon termination of coverage, an extension of benefits shall be provided for any treatment in progress at the time of termination, provided the treatment requires two or more visits on separate days to the dentist's office. Extension of benefits will be limited to 90 days for all care other than orthodontics, and 60 days for orthodontics if the orthodontist has agreed to or is receiving monthly payments when coverage terminates, or to the end of the quarter in progress or 60 days, whichever is longer, if the orthodontist is receiving quarterly payments. An extension of benefits will not be provided if termination was due to a failure of the Subscriber to pay the Premiums or fraud or material misrepresentation by the Subscriber or Dependent.

Part V. PREMIUMS AND MEMBER COPAYMENTS

Members are entitled to dental coverage for the period for which the Plan has received the appropriate Premium from the Group. Subscriber is responsible to pay any required contribution to the Premium, as determined and required by the Group. The Group will tell the Subscriber the amount owed and how the Subscriber will pay the Premium to the Group. For example: A payroll deduction.

Please refer to the attached Description of Services, Member Copayments, Exclusions, and Limitations for a list of Copayment amounts due to the Participating Dentist at the time services are rendered.

Part VI. BENEFITS AND COVERAGES

All dental procedures listed under the attached Description of Benefits and Member Copayments will be provided if they are necessary for the patient's dental health. The fee charged will be the fee listed under Member Copayments for each procedure completed. If conflict arises regarding the quality, cost, or extent of work performed pursuant to the Plan, the case in question will be resolved pursuant to the Complaint or Quality Assurance Procedures established by the Plan.

PARTICIPATING REFERRAL: Referrals to a Plan Specialist must be made by the Member's Participating Dentist, except in the case of orthodontics.

NON-PARTICIPATING REFERRAL: If a Participating Dentist refers the Member to a nonparticipating specialist for dental services, which are covered under this agreement, the Plan shall be responsible for payment of the specialist's charges to

the extent the charges exceed the copayments specified in the Description of Benefits and Member Copayments.

If during the term of this Contract none of the plan dentists can render necessary care and treatment to the Member due to circumstances not reasonably within the control of the Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the plan dentists, then the Member may seek treatment from an independent licensed dentist of his own choosing. The Plan will pay the Member for the expenses incurred for the dental services with the following limitations: The Plan will pay the Member for services which are listed in the Description of Benefits and Member Copayments as 'No Charge', to the extent that such fees are reasonable and customary for dentists in the same geographic area. The Plan will also pay the Member for those services for which there is a Copayment, to the extent that the reasonable and customary fees for such services exceed the Copayment for such services as set forth in the Description of Benefits and Member Copayments. The enrollee may be required to give written proof of loss.

PRE-AUTHORIZATION OF BENEFITS: The Plan strongly advises the treating dentist to submit a treatment plan prior to initiating services, but it is not required. In accordance with its review guidelines, the Plan may request x-rays or other dental records, prior to issuing the pre-authorization. The proposed services will be reviewed and a pre-authorization will be issued to the Member or dentist, specifying coverage. The pre-authorization is not a guarantee of coverage and is considered valid for 180 days.

ALTERNATE BENEFIT: If: 1) Plan determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and 2) the alternate treatment will produce a professionally satisfactory result; then the maximum the Plan will allow will be the charge for the less expensive treatment.

Part VII. STATE-SPECIFIC EXCLUSIONS

There are no state-specific exclusions under your plan. For a complete list of exclusions, please refer to your Description of Benefits and Member Copayments.

Part VIII. DENTAL RECORDS

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

Part IX. CHANGE IN SERVICE

Plan reserves the right to change the Premiums or Member Copayments 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 X. CONVERSION AND CONTINUATION OF COVERAGE

Plan coverage will terminate for Group Subscribers and their Dependents when Subscriber is no longer associated with the Group. Thereafter, and subject to Part III A and B only, Subscriber and their Dependents may convert to an individual contract. Plan will provide a conversion form with the details of the benefit plan available and the Premiums. Subscriber must remit the conversion form and Premiums to Plan within 31 days after termination. 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 (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 XI. EMERGENCY SERVICES

When a Member is more than 50 miles from their Participating Dentist, they may have emergency services rendered by any licensed dentist. Emergency services is defined as "palliative care of injury, toothache, or accident requiring the immediate attention of a dentist or hospital/ambulatory surgical care center." Plan reimburses for emergency out-of-area services up to $100 per incident. Any amount that is not reimbursed will contribute to the Out-of-Pocket Maximum. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Plan must be notified of such treatment within five (5) days of the Member's return to their area. Proof of loss must be submitted to Plan within ninety (90) days of treatment. Proof of loss should be mailed to: Dominion National, 251 18th Street S., Suite 900, Arlington, VA 22202, ATTN: Accounting Dept.

When a Member has a dental emergency within the service area, but is unable to make arrangements to receive care through their Participating Dentist, treatment must be pre-authorized by contacting Customer Service at (888) 518-5338.

Part XII. CLAIMS FOR NON-EMERGENCY SERVICES

PAYMENT OF CLAIMS: If Plan provides coverage of a Member as a Dependent of a parent who has legal responsibility for the Dependent's dental 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 dentist. 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 dentist. 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 dentist, benefits will be paid to the Member's estate.

Consistent with pre-authorization of benefits, Plan may request supporting documentation in accordance with its review guidelines in order to make a benefit determination.

CHANGE OF BENEFICIARY: The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

CLAIM FORMS/NOTICE OF CLAIM: Plan must receive written notice of claim within 20 days after the occurrence or commencement of any loss covered by the Plan. If Plan receives a notice of claim, it will provide claim forms for filing proof of loss. If such forms are not sent within 15 days after notice of claim is received, the claimant will be deemed to have complied with the requirements of this Contract as to proof of loss. Instructions for submitting notice of claim to Plan can be found on the Member's Identification Card.

PROOF OF LOSS: Plan must receive written proof of loss within 180 days of treatment. Upon loss occurring within 90 days after the termination period in which Plan is liable, Plan shall be responsible for such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required Instructions for submitting proof of loss to Plan can be found on the Membership Identification Card.

EXPLANATION OF BENEFITS: The Plan will make available to you notice of our claims processing, called an Explanation of Benefits. The Explanation of Benefits explains our payment or our reason(s) for nonpayment of the claim.

TIME OF PAYMENT OF CLAIM: Benefits payable under this Contract for any loss will be paid immediately after receipt of proof of loss that contains the required supporting documentation.

PHYSICAL EXAMINATIONS AND AUTOPSY: The Plan at its own expense shall have the right and opportunity to examine the Member(s) of the Plan when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Part XIII. INCONTESTABILITY CLAUSE AND LEGAL ACTIONS

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.

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 XIV. HOW TO RECEIVE BENEFITS

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

Part XV. APPEALS, COMPLAINTS, AND GRIEVANCES

The following definitions apply only to this section:

A. **Adverse Benefit Determination** shall mean a determination by the Plan, a private review agent or a dentist acting on behalf of the Plan that results in a denial, reduction or termination of a benefit or amount paid for a service. It also may mean a decision not to provide a benefit or service.
B. **Appeal** shall mean a protest filed through the Plan's internal appeal process by a Member, Member's personal representative or a dentist on behalf of a Member regarding an Adverse Benefit Determination. The Appeal can either be non-clinical (benefit payment, denial of coverage, reimbursement for services) or clinical (plan determination of necessity). See step 2 below.
C. **Appeal Decision** shall mean a final determination by the Plan that arises from an Appeal filed with the Plan under its appeal process regarding an Adverse Benefit Determination.
D. **Complaint** shall mean an informal, verbal dispute with the Plan or provider, regarding the quality of care and/or service, or operational issues such as waiting time at a provider office, network adequacy, etc. Complaints are resolved by Customer Service of the Plan. See step 1 below.
E. **Grievance** shall mean a formal, written dispute regarding a Complaint that has not been resolved to the Member's satisfaction. Grievances are resolved by the Grievances and Appeals Department of the Plan. See step 2 below.
G. **Inquiry** shall mean the first contact with Dominion (verbal or written) requesting information or assistance. See step 1 below.

Patient Care Issues:

Issues involving patient care should initially be brought to the attention of the Member's Participating Dentist. Note that Dominion's contracted providers maintain the dentist-patient relationship and are solely responsible for dental services – we simply administer the plan and benefits. Dominion respects the dentist-patient relationship and encourages our Members to discuss all treatment options and care with the treating dentist. Dominion is limited to a general review mostly related to the participating agreement with the dentist to encompass the accurate submission of claims for completed services, general quality of care, and to ensure that benefits are delivered in accordance to the Member's dental plan benefits. If you have a concern relating to dental care with a Participating Dentist, you should first reach out to the Participating Dentist for discussion. Dominion encourages communication between our Members and Participating Dentists to come to a mutually satisfactory resolution.

For all other concerns, please follow the below steps.

Step 1:

Most Member issues can be resolved verbally over the telephone. If a Member has discussed a Complaint relating to dental care with a Participating Dentist and is not satisfied with the resolution (or if the Participating Dentist is not available to receive the Complaint), the Member may refer

the Complaint to Customer Service by calling toll-free 888.518.5338. The Complaint will be investigated and the result of the investigation will be verbally communicated to the member within thirty (30) working days after receipt of the Complaint.

Step 2:
If the matter cannot be resolved in Step 1, a Member or dentist may submit it in writing to Grievances and Appeals, c/o Dominion National, 251 18th Street South, Suite 900, Arlington, VA 22202 or fax 703.518.4450. Grievances and Appeals will acknowledge receipt of the Appeal and/or Grievance to the Member or dentist in writing within thirty (30) days. Grievances and Appeals will then conduct a review of the Appeal and/or Grievance and initiate any correspondence necessary to resolve it.

If the matter involves significant health services, quality or ethical aspects, the matter will be referred to the Director of Provider Relations. The Director of Provider Relations will consult with parties involved and may contact members of the Quality Assurance Committee to review findings.

The Member and/or dentist will receive a final Appeal Decision and/or Grievance response in writing within 60 days after the date on which the Appeal and/or Grievance is filed. All Appeals and/or Grievances should be provided to the Plan within 180 days of the Adverse Benefit Determination or date of occurrence resulting in the Grievance. If additional time is needed to resolve the issue, the member or dentist will be notified in writing. Appeals and Grievances will be categorized by type or subject matter and presented to the Quality Assurance Committee.

When corresponding with Dominion regarding an Appeal and/or Grievance, Members must indicate their name, address and phone number, as well as the group number listed on their I.D. card.

Step 3:
If a Member is dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you 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 One Judiciary Square 441 4th St. N.W., Suite 900 South Washington, D.C. 20001 (877) 685-6391, (202) 724-7491 Fax: (202) 442- 6724.

If a Member is dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non -Medical Necessity cases, Commissioner, Department of Insurance, Securities and Banking 1050 First Street, N.E., Suite 801 Washington, D.C. 20002 Phone: (202) 727 -8000 Fax: (202) 354 -1085 E-mail: disb@dc.gov.
The representative of the Plan who is responsible for the internal appeal and grievance process is: Carey Wintz, Director of Quality, Dominion National, 251 18th Street S., Suite 900, Arlington, VA 22202, Telephone: (703) 518-5338 or (888) 518-5338, Fax: (703) 518-4450. When filing a complaint with the Commissioner, the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the complaint.

No Member who exercises the right to file a Complaint, Grievance, or Appeal shall be subject to disenrollment or otherwise penalized due to the filing of a Complaint, Grievance, or Appeal.

Part XVI. CONFORMITY WITH LAW
Any provision in this policy that is in conflict with the requirements of any state or federal law that apply to this policy are automatically change to satisfy the minimum requirements of such laws.

Part XVII. 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:

Commissioner
District of Columbia Department of Insurance, Securities and Banking

1050 First Street, N.E., Suite 801
Washington, D.C. 20002
(202) 727-8000
Fax: (202) 354-1085

Or

Mr. Robert Willis, Executive Director
District of Columbia Life and Health Insurance Guaranty Association
1200 G St. N.W., Washington, D.C., 20005
(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 is 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 contacts.

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.

Part XIVIII. ENTIRE CONTRACT
The Group Dental Service 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 Dominion Dental Services, Inc. will constitute part of the Contract. No change in this Contract shall be valid until approved by an executive officer of the Plan and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Contract or to waive any of its provisions.

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

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