DELTA DENTAL

# Delta Dental PPO (Point-of-Service)

This Contract is effective the 1st day of January, 2012 A.D., by and between City of Gahanna, hereinafter referred to as the Contractor and Delta Dental Plan of Ohio, Inc., an Ohio non-profit corporation, hereinafter referred to as Delta Dental.

## *Section I. Declarations*

The benefits afforded are only with respect to such benefits as are indicated in this Contract. Delta Dental's liability is limited to the benefits stated herein; subject to all the terms of this Contract having reference thereto. This Declarations Section supersedes any contrary provision of the subsequent sections of this Contract.

A. **Effective Date of Contract Year:** 12:01 A.M. Standard Time, January 1, 2012 A.D.

B. **First Renewal Date:** January 1, 2013

C. **Group Number:** 0273-0005

D. **Eligibility (Subscribers and dependents):**

All full-time employees of the Contractor and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable.

Dependents of above mentioned Subscribers are also eligible.

Where two legally married subscribers are both eligible for coverage under this contract, they may be enrolled together on one application card or separately on individual application cards, but not both. Dependent children may only be enrolled on one application card. Delta Dental will not coordinate benefits for married subscribers who are both eligible under this contract.

E. **Waiting Period:**

All new Subscribers (and their dependents, if covered above), defined as eligible Subscribers added to the covered group who are hired after the effective starting date of the Contract will be eligible for enrollment on the first day of the month following the date of hire.

F. **Deductible:** None.



EXHIBIT A

G. **Covered Services:**

| | PPO Dentist | Premier Dentist | Non-participating Dentist |
|---|---|---|---|
| | Plan Pays | Plan Pays | Plan Pays |
| **Diagnostic & Preventive** | | | |
| **Diagnostic and Preventive Services** - includes exams, cleanings, fluoride, and space maintainers | 100% | 100% | 100% |
| **Emergency Palliative Treatment** - to temporarily relieve pain | 100% | 100% | 100% |
| **Brush Biopsy** - to detect oral cancer | 100% | 100% | 100% |
| **Radiographs** - X-rays | 100% | 100% | 100% |
| **Basic Services** | | | |
| **Minor Restorative Services** - fillings and crown repair | 75% | 75% | 75% |
| **Endodontic Services** - root canals | 75% | 75% | 75% |
| **Periodontic Services** - to treat gum disease | 75% | 75% | 75% |
| **Oral Surgery Services** - extractions and dental surgery | 75% | 75% | 75% |
| **Major Restorative Services** - crowns | 75% | 75% | 75% |
| **Other Basic Services** - misc. services | 75% | 75% | 75% |
| **Relines and Repairs** - to bridges and dentures | 75% | 75% | 75% |
| **Major Services** | | | |
| **Prosthodontic Services** - includes bridges, implants, and dentures | 75% | 75% | 75% |
| **Orthodontic Services** | | | |
| **Orthodontic Services** - includes braces | 75% | 75% | 75% |
| **Orthodontic Age Limit** - | Up to age 19 | Up to age 19 | Up to age 19 |

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Enrollees can receive expert dental care when they are outside of the United States through our Passport Dental program. Passport Dental gives our enrollees access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help them schedule care. Delta Dental coverage outside of the United States is the same as Delta Dental coverage within the United States. Access to the Passport Dental program is offered through an agreement with a third party vendor, and it may not be available if that agreement terminates.

H. **Maximum Payment:** $1,500 per person total per calendar year on all services except orthodontics. $1,500 per person total per lifetime on orthodontic services.

**I. Rate(s):**

Composite - $91.09 per month per Subscriber

Rates do not include any applicable claims taxes.

This rate is contingent upon 100 percent enrollment of the eligible members of the defined group and their eligible dependents with the entire cost of coverage paid by the Contractor.

These rates are valid only while City of Gahanna is a member of Central Ohio Health Care Consortium (COHCC). If this affiliation is terminated, Delta Dental reserves the right to adjust these rates or terminate this contract.

## *Section II. Definitions*

**A. Benefits**

means payment for dental services that have been selected under the Contract.

**B. Children**

means the Subscriber's natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with the Subscriber during the waiting period for adoption or legal guardianship.

**C. Concurrent Care Claims**

means claims for benefits where an ongoing course of treatment has been agreed to by Delta Dental and/or the administrator of the Plan and the coverage for that treatment is reduced or terminated before the treatment has been completed. A Concurrent Care Claim may also arise if the eligible person asks the Plan to extend coverage beyond the time period or number of treatments previously agreed to.

**D. Contract**

means this document, including, if applicable, any appendices, supplements, riders, successor agreements, evergreen renewal letters, or renewals now or hereafter issued or executed.

**E. Contract Year**

means the 12-month period beginning on the first effective date of the Contract and each 12-month renewal period thereafter.

**F. Copayment**

means the percentage of the charge, if any, that the Subscriber must pay for Covered Services.

**G. Covered Services**

means the unique dental services selected for Benefits as described in the Declarations Section and subject to the terms and conditions of this Contract.

**H. Deductible**

means the amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for services under this Contract. If the Contractor has selected a Deductible, it will be indicated in the Declarations Section.

**I. Delta Dental**

means Delta Dental Plan of Ohio, Inc., a health insuring corporation providing dental service benefits. Delta Dental is not a commercial insurance company.

**J. Delta Dental Plan**

means an individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

**K. Delta Dental PPO (Point-of-Service) (PPO)**

means Delta Dental's preferred provider organization program that can reduce out-of-pocket expenses for eligible people if they receive care from one of Delta Dental's PPO Dentists. This program has back-up coverage through Delta Dental Premier when treatment is received from a non-PPO Dentist.

**L. Delta Dental Premier**

means Delta Dental's fee-for-service dental benefits program that covers an eligible person only when services are rendered by a non-PPO Dentist.

**M. Dentist**

means a person licensed to practice dentistry in the state or country in which dental services are rendered.

1. **Delta Dental PPO Dentist (PPO Dentist) or Participating Dentist** means a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO. PPO Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.

2. **Delta Dental Premier Dentist (Premier Dentist) or Participating Dentist** means a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier. Delta Dental Premier Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.

   Wherever a definition or provision of this Contract differs from another state's Delta Dental Plan and its agreement with a Participating Dentist, the agreement in that state with that Dentist shall be controlling.

3. **Nonparticipating Dentist** means a Dentist who has not signed an agreement with Delta Dental to participate in Delta Dental PPO or Delta Dental Premier.

4. **Out-of-Country Dentist** means a Dentist whose office is located outside of the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

**N. Eligible Dependent**

means (a) the Subscriber's legal spouse and (b) any other dependents who meet the criteria for eligibility set forth in the Declarations and Eligibility Sections. If dependent coverage has been selected, it will be indicated in the Declarations Section.

**O. Maximum Approved Fee**

means a system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental Premier Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

1. The Submitted Amount.

2. The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service, irrespective of Dentist's contractual agreement with another dental benefits organization.

3. The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances.

Delta Dental may also approve a fee under unusual circumstances.

Participating Dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for the Covered Service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the Covered Service.

**P. Maximum Payment**

means the maximum dollar amount Delta Dental will pay in any benefit year or lifetime for covered dental services. The Maximum Payment is specified in the Declarations Section.

**Q. Nonparticipating Dentist Fee**

means the maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist.

**R. Out-of-Country Dentist Fee**

means the maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist.

**S. Plan**

means the arrangement for the provision of dental benefits to eligible people established by the Contract between Delta Dental and the employer or organization.

**T. Post-Service Claims**

means claims for Benefits that are not conditioned on eligible people seeking advance approval, certification, or authorization to receive the full amount of any covered benefit. In other words, Post-Service Claims arise when an eligible person receives the dental service or treatment before the claim is filed for the benefit payment.

**U. PPO Dentist Schedule**

means the maximum amount allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan

**V. Predetermination (Pre -Service Claims)**

means an estimate of the costs of Covered Services to be provided. A Dentist may submit his or her treatment plan to Delta Dental before providing services. Delta Dental reviews the treatment plan and advises the eligible person and their Dentist of what services are covered by the Plan and what Delta Dental's payments may be. Delta Dental's payment for predetermined services depends on continued eligibility and the annual or lifetime Maximum Payments available under the Plan. An eligible person is not required to seek a Predetermination. He or she will receive the same benefits under the Plan whether or not a Predetermination is requested. Predetermination is merely a convenience so that the eligible person will know before the dental service is provided how much, if any, of the cost of that service is not covered under the Plan. Since an eligible person may be responsible for any cost not covered under the Plan, this is likely to be useful information for him or her when deciding whether to incur those costs.

**W. Processing Policies**

means Delta Dental's policies and guidelines used for predetermination and payment of claims. The Processing Policies may be amended from time to time.

**X. Rate**

means the amount, per Subscriber and Subscriber classification, the Contractor agrees to pay Delta Dental each month. This amount, or the information necessary to compute it, is specified in the Declarations Section.

**Y. Submitted Amount or Submitted Fee**

means the fee a Dentist bills to Delta Dental for a specific treatment.

**Z. Subscriber**

means all people who are certified as being eligible by the Contractor and are members of the group specified in the Declarations Section.

**AA. Urgent Care Claims**

are those potentially life-threatening claims as defined in the U.S. Department of Labor Regulations at 29 CFR 2560.503-1 (M) (1) (I). Any such claims that may arise under this dental coverage are not considered to be Pre-Service Claims and are not subject to any Predetermination requirements.

## *Section III. Eligibility*

**A. Effective Date of Eligibility**

1. **Initial effective date:** All Subscribers on the effective date of this Contract are immediately eligible for dental benefits. If dependents of the Subscribers are covered by this Contract, their eligibility commences on the same date as the Subscribers'.

2. **After the initial effective date:** For all Subscribers (and their Eligible Dependents, if specified in this Contract) not associated with the Contractor on the initial effective date of this Contract, eligibility for dental benefits will begin following whichever of the following dates is applicable; provided, however, that for Sections III.A.2.c., 2.d., and 2.f., in those circumstances when dental benefits are not "excepted benefits," as defined in Section 9832(c) of the Internal Revenue Code of 1986, as amended ("IRC" or the "Code"), the eligibility for dental benefits will begin on the applicable date set forth therein:

   a. Newly hired or rehired employees: The date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Declarations Section.

   b. Spouse: Date of marriage.

   c. Newborn: Date of birth.

   d. Legal adoptions or guardianships: Date that the legal petition for adoption or guardianship becomes legally final or while children are residing with the Subscriber and the Subscriber assumes responsibility for the child while waiting for adoption or guardianship to become final.

   e. Stepchild: Date that the child's natural parent becomes an Eligible Dependent.

f. Special Enrollment Periods: For dental benefits not provided under a group health plan providing only dental benefits and where the dental benefits are "integral" to the group health plan (i.e., where dental benefits are not "excepted benefits" under IRC Section 9832(c)), the date required under the special enrollment provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, Section 701(f), and IRC Section 9801(f).

For the special enrollment periods provided under ERISA Section 701(f)(3)(A)(i) and IRC Section 9801(f)(3)(A)(i), relating to the loss of coverage under a state Medicaid program or a state children's health insurance program ("CHIP") or the availability of a premium assistance subsidy under either of those programs under ERISA Section 701(f)(3)(A)(ii) and IRC Section 9801(f)(3)(A)(ii), the enrollment period will be 60 days following the loss of coverage under either state program or the date you are determined to be eligible for a premium assistance subsidy. For coverage under ERISA Section 701(f)(3)(A)(ii) and IRC Section 9801(f)(3)(A)(ii) on account of eligibility for a premium assistance subsidy, the group health plan must be "Qualified Employer-Sponsored Coverage," which means that (i) the Plan constitutes creditable coverage for HIPAA purposes, (ii) the Contractor's contribution toward the cost of any premium or premium equivalent is at least 40 percent, and (iii) the coverage under the group health plan is available on a non-discriminatory basis under IRC Section 105(h).

g. All others: Date that Delta Dental approves in writing the enrollment or listing of those people.

**B. General Eligibility Rules**

1. No person will be eligible for dental benefits under this Contract unless the Contractor has either currently enrolled that person as a Subscriber or currently listed or acknowledged that person as an Eligible Dependent unless the enrollment or listing is allowed under this Contract. To the extent the dental benefits provided under this Contract are not "excepted benefits," as defined in IRC Section 9832(c), no person will be ineligible for dental benefits under this Contract on account of any of the health status-related factors set forth in ERISA Section 702(a)(1) and IRC Section 9802(a)(1).

2. Unless the eligibility requirements stated in the Declarations Section are different, an Eligible Dependent is:

   a. The legal spouse of the Subscriber; or

   b. Unmarried Children of the Subscriber who have not yet reached the end of the calendar year of their 19th birthday; or

   c. Unmarried Children of the Subscriber who are over age 19 and eligible to be claimed by the Subscriber as a dependent under the U.S. Internal Revenue Code during the current calendar year; or

   d. Unmarried Children of the Subscriber or the Subscriber's legal spouse for whom the Subscriber or the Subscriber's legal spouse is financially responsible for the medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients, as defined in ERISA Section 609(a)(2)(C), under a qualified medical child support order, as defined in ERISA Section 609(a)(2)(A); or

e. Children of the Subscriber who are over age 19, but who were (and continue to be) totally and permanently disabled before age 19 by a physical or mental condition and who are eligible to be claimed by the Subscriber or the Subscriber's legal spouse as dependents under the U.S. Internal Revenue Code. If Delta Dental asks the Subscriber to do so, the Subscriber shall submit medical reports confirming the child's initial or continuing total disability.

3. No person will be eligible for orthodontic benefits under this Contract unless Class IV benefits are selected in the Declarations Section and, even if Class IV benefits are selected, no person will be eligible for orthodontic benefits on or after that person's 19th birthday, unless specified otherwise in the Declarations Section.

**C. Termination of Eligibility**

Eligibility for dental benefits will terminate for all eligible people under this Contract at the earlier of:

1. The termination of this Contract; or

2. The last day of the month for which payment has been made if the Contractor fails to make the payments required by this Contract.

Eligibility of an individual Subscriber, and of that Subscriber's Eligible Dependents, will also terminate if that Subscriber ceases to be a Subscriber as defined by this Contract. An Eligible Dependent also terminates upon lack of compliance with the eligibility requirements of this Contract.

Delta Dental will not continue eligibility for any person covered under this Contract beyond the eligibility termination date requested by the Contractor. However, if the Contractor requests that a person's eligibility be terminated retroactively and a claim was incurred for any eligible member of that person's family after the requested termination date, the person's eligibility will continue at the expense of the Contractor until the end of the month in which the claim was incurred. A person whose eligibility is terminated may not continue group coverage under this Contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or comparable, non-preempted state law. An affiliate of Delta Dental also may offer coverage under an individual direct payment policy to a person whose eligibility is terminated.

**D. Loss of Eligibility During Treatment**

1. If an eligible person loses eligibility while receiving dental treatment, only Covered Services received while that person was eligible under the plan will be payable.

2. Certain services begun before the loss of eligibility may be covered if they are completed within a 60-day period measured from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The balance of the total fee is the Subscriber's responsibility.

**E. Continuation Coverage – COBRA**

The other provisions of this section notwithstanding, eligibility for dental benefits will continue for a person who is required to be provided with and elects continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) provided:

1. Continuation coverage is required to be provided under COBRA. Not all employers are subject to the continuation coverage requirements contained in COBRA. For those that are not, this Section III.E. does not apply. Employers should consult with their legal counsel to determine how and when the law applies.

2. Continuation coverage shall only be in effect up to the first day of the month after the person notifies the Contractor that he or she no longer wants coverage from Delta Dental, the date a COBRA premium payment was due and was not remitted by the end of the COBRA Grace Period, or until the end of that person's continuation coverage period, whichever occurs first.

3. Further, if the Contractor fails to make payments required by this Contract, continuation coverage shall only remain in effect until the last day of the month for which payment has been made to Delta Dental by the Contractor; provided, however, that any payment for COBRA continuation coverage received during a period that is 30 days following the date the COBRA premium payment was due (the "COBRA Grace Period") will provide continuation coverage from the due date. A person's coverage may be retroactively reinstated for the 60-day COBRA "election" period if the Contractor pays the applicable rate for the period within the 45-day period following the date of the COBRA election. Delta Dental may, at its sole option and without notice, continue coverage, if legally required.

4. Continuation coverage will not continue beyond the termination of this Contract.

5. The person who is receiving continuation coverage is responsible for the costs of any service provided after he or she is no longer eligible for continuation coverage under this Section III.E.

6. It is the Contractor's responsibility to provide Delta Dental with proper and timely notification of any event that would terminate the person's continuation coverage, and the Contractor will be liable to Delta Dental for any rate due on account of any untimely, improper, or inaccurate notice.

7. The monthly rate that must be paid on behalf of any person who is provided coverage under this subsection will be based on the COBRA continuation coverage rates then in effect during that month.

8. A person who continues coverage will be considered to be either a Subscriber or an Eligible Dependent under this Contract and the dental care certificate as long as coverage is provided under this Section III.E.

9. Delta Dental does not assume any of the obligations assigned by COBRA to the Contractor (including the obligation to notify potential beneficiaries of their rights or options under COBRA), and the Contractor agrees that it will perform those obligations in full.

## *Section IV. Benefits*

**Types of Dental Benefits**

Delta Dental agrees to provide Benefits to Subscribers and Eligible Dependents under the policies and procedures of Delta Dental, including the Processing Policies, and under the terms and conditions of this Contract, including, but not limited to, the following classifications, exclusions, and limitations. Benefits will be divided into the following classes **unless otherwise specified in the Declarations Section:**

1. **Class I Benefits**

   a. **Diagnostic and Preventive Services**

      Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations/evaluations, prophylaxes (teeth cleanings), space maintainers, and fluoride treatments.

**b. Brush Biopsy**

Oral brush biopsy procedure and laboratory analysis to detect oral cancer, an important tool that uses "Star Wars" technology to identify and analyze precancerous and cancerous cells. The brush biopsy represents a breakthrough in the fight against oral cancer. Using this diagnostic procedure, dentists can identify and treat abnormal cells that could become cancerous, or they can detect the disease in its earliest and most treatable stage. The test is quick, accurate, and involves little or no patient discomfort.

**c. Emergency Palliative Treatment**

Emergency treatment to temporarily relieve pain.

**d. Radiographs**

X-rays as required for routine care or as necessary for the diagnosis of a specific condition.

**2. Class II Benefits**

**a. Oral Surgery Services**

Extractions and dental surgery, including preoperative and postoperative care.

**b. Endodontic Services**

The treatment of teeth with diseased or damaged nerves (for example, root canals).

**c. Periodontic Services**

The treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal prophylaxes).

**d. Relines and Repairs**

Relines and repairs to bridges, partial dentures, and complete dentures.

**e. Restorative Services**

Services to rebuild and repair natural tooth structure damaged by disease or injury. Restorative services include:

**(1)** Minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings.

**(2)** Major restorative services, such as crowns, used when teeth cannot be restored with another filling material.

**3. Class III Benefits**

**Prosthodontic Services**

Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, partial dentures, and complete dentures).

**4. Class IV Benefits**

**Orthodontic Services**

Services, treatment, and procedures to correct malposed teeth (for example, braces).

## *Section V. Exclusions and Limitations*

**A. Delta Dental will make no payment for the following services, unless otherwise specified in the Declarations Section, and all charges for the following services will be the responsibility of the Subscriber:**

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX Social Security Act; that is, Medicaid.
2. Services, as determined by Delta Dental, for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before a person became eligible under this Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
4. Prescription drugs (except intramuscular injectable antibiotics), premedications, medicaments/solutions, and relative analgesia.
5. General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless medically necessary.
6. Charges for hospitalization, laboratory tests, and histopathological examinations.
7. Charges for failure to keep a scheduled visit with the Dentist.
8. Services, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature as determined by the standards of generally accepted dental practice.
9. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
10. Those benefits excluded by the policies and procedures of Delta Dental, including the Processing Policies.
11. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
12. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
13. Services that are covered under a hospital, surgical/medical, or prescription drug program.
14. Services that are not within the classes of benefits that have been selected and that are not in the Contract.
15. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
16. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
17. Sealants.
18. Space maintainers for maintaining space due to premature loss of anterior primary teeth.

19. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.

20. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.

21. Veneers.

22. Prefabricated crowns used as final restorations on permanent teeth.

23. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion; or for periodontal splinting. If orthodontic services are Covered Services, this exclusion will not apply to orthodontic services as limited by the terms and conditions of the Plan.

24. Paste-type root canal fillings on permanent teeth.

25. Replacement, repair, relines, or adjustments of occlusal guards.

26. Chemical curettage.

27. Prosthodontic services (Class III Benefits).

28. Services associated with overdentures.

29. Metal bases on removable prostheses.

30. The replacement of teeth beyond the normal complement of teeth.

31. Personalization/characterization of any service or appliance.

32. Temporary appliances.

33. Posterior bridges in conjunction with partial dentures in the same arch.

34. Precision attachments.

35. Specialized implant surgical techniques.

36. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

37. Orthodontic services (Class IV Benefits).

38. Diagnostic photographs and cephalometric films, unless done for orthodontics.

39. Myofunctional therapy.

40. Mounted case analyses.

**Delta Dental will make no payment for the following services, unless otherwise specified in the Declarations Section. Participating Dentists cannot charge eligible people for these services. All charges from Nonparticipating Dentists for the following services will be the responsibility of the Subscriber:**

41. The completion of claim forms.

42. Consultations, when performed in conjunction with examinations/evaluations or diagnostic procedures.

43. Local anesthesia.

44. Acid etching, cement bases, cavity liners, and bases or temporary fillings.

45. Infection control.

46. Temporary crowns.

47. Gingivectomy as an aid to the placement of a restoration.

48. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.

49. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.

50. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.

51. Post-operative X-rays, when done following any completed service or procedure.

52. Periodontal charting.

53. Pins and/or preformed posts, when done with core buildups for crowns, onlays, or inlays.

54. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

55. A pulpotomy on a permanent tooth, except on a tooth with an open apex.

56. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.

57. Retreatment of a root canal by the same Dentist or dental office within 24 months of the original root canal treatment.

58. A prophylaxis or subgingival curettage, when done on the same day as root planing.

59. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.

60. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.

61. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

**B. The Benefits for the following services are limited as follows, unless otherwise specified in the Declarations Section. All charges for services that exceed these limitations will be the responsibility of the Subscriber. All time limitations are measured from the last date of service in any Delta Dental plan or, at the request of the Contractor, any dental plan:**

1. Bitewing X-rays are payable once in any period of 12 consecutive months. Full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period. A panographic X-ray (including bitewings) is considered a full mouth X-ray.

2. Prophylaxes, including periodontal prophylaxes, and routine oral examinations/evaluations are payable twice in any period of 12 consecutive months.

3. Preventive fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.

4. Space maintainers are payable for people up to age 14.

5. Cast restorations (including jackets, crowns, and onlays) and associated procedures (such as core buildups and post substructures) on the same tooth are payable once in any five-year period.

6. Crowns or onlays are payable only for extensive loss of tooth structure due to caries and/or fracture.

7. Individual crowns over implants are payable at the prosthodontic benefit level.

8. Porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.

9. An occlusal guard is a benefit once in a lifetime.

10. An interim partial denture is a benefit only for the replacement of permanent anterior teeth during the healing period or for people up to age 17 for missing permanent anterior teeth.

11. Prosthodontic (Class III) benefit limitations:

    a. One complete upper and one complete lower denture are benefits once in any five-year period for any person.

    b. A removable partial denture, implant, or fixed bridge for any person can be covered once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.

    c. Fixed bridges and removable cast partial dentures are not payable for people under age 16.

    d. A reline or the complete replacement of denture base material is limited to once in any three-year period per appliance.

12. Orthodontic (Class IV) benefit limitations:

    a. Orthodontic benefits are payable for eligible people up to age 19.

    b. If the treatment plan is terminated before completion of the case for any reason, Delta Dental's obligation will cease with payment to the date of termination.

    c. The Dentist may terminate treatment, with written notification to Delta Dental and to the patient, for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment of benefits ends on the last day of the month in which the patient was last treated.

    d. An observation and adjustment is a benefit twice in a 12-month period.

13. Delta Dental's obligation for payment of benefits ends on the last day of the month in which coverage is terminated. However, Delta Dental will make payment for Covered Services provided on or before the last day of the month in which coverage was terminated as long as it receives a claim for those services within one year of the date of service.

14. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.

15. Care terminated due to the death of an eligible person will be paid to the limit of Delta Dental's liability for the services completed or in progress.

16. Optional treatment: If an eligible person selects a more expensive service than is customarily provided or for which Delta Dental does not determine a valid dental need is shown, Delta Dental can make an allowance based on the fee for the customarily provided service.

    For example, if a tooth can be satisfactorily restored with an amalgam (silver) or composite resin (white) restoration and the eligible person chooses to have the tooth restored with a more costly procedure, such as an inlay, the Plan will pay only the amount that it would have paid to restore the tooth with amalgam or composite resin. The eligible person is responsible for the difference in cost.

    Listed below are some other examples of common optional services:

    a. Porcelain fused to metal and porcelain crowns on posterior teeth – the Plan will pay only the applicable amount that it would have paid for a full metal crown.

    b. Overdentures – the Plan will pay only the applicable amount that it would have paid for a conventional denture.

    c. Porcelain/ceramic onlays – the Plan will pay only the applicable amount that it would have paid for a metallic onlay.

    d. Inlays, regardless of the material used – the Plan will pay only the applicable amount that it would have paid for an amalgam or composite resin restoration.

    e. Soft relines – the Plan will pay only the applicable amount that it would have paid for a conventional reline.

    f. All-porcelain/ceramic bridges – the Plan will pay only the applicable amount that it would have paid for a conventional fixed bridge.

17. Maximum Payment:

    a. The maximum benefit payable in any one benefit year will be limited to the amount specified in the Declarations Section.

    b. Delta Dental's payment for orthodontic (Class IV) benefits will be limited to the annual or lifetime maximum per person specified in the Declarations Section.

18. If a Plan Deductible amount is specified in the Declarations Section, Delta Dental will not be obligated to pay for, in whole or in part, any services to which the Deductible applies until the Plan Deductible amount is met.

19. Processing Policies may limit treatment.

**Delta Dental will make no payment for services that exceed the following limitations, unless otherwise specified in the Declarations Section. Participating Dentists cannot charge eligible people for these services. All charges from Nonparticipating Dentists for services that exceed these limitations will be the responsibility of the Subscriber:**

20. Amalgam and composite resin restorations by the same Dentist or dental office are payable once within a 24-month period, regardless of the number or combination of restorations placed on a surface.

21. Core buildups and other substructures are benefits only when needed to retain a crown on a tooth with excessive breakdown due to caries and/or fractures.

22. Recementation of a crown, onlay, inlay, space maintainer, or bridge by the same Dentist or dental office within six months of the seating date.

23. Retention pins are benefits once in a 24-month period. Only one substructure per tooth is a benefit.

24. Benefits for root planing by the same Dentist or dental office are payable once in any two-year period.

25. Periodontal surgery, including subgingival curettage, by the same Dentist or dental office is payable once in any three-year period.

26. A complete occlusal adjustment is a benefit once in a five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not a benefit more than three times in a five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.

27. Tissue conditioning is not a benefit more than twice per arch in 36 months.

28. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.

29. Processing Policies may limit treatment.

## *Section VI. Agreements*

**A. Delta Dental Agrees:**

1. To provide all dental claims processing, service, and dental benefits administration for the Contractor.

2. To make no payments from the money received from the Contractor for any services rendered to a person who is not eligible for dental benefits as defined in this Contract; provided, however, that Delta Dental receives timely information from the Contractor regarding the eligibility of each Subscriber and Eligible Dependent, as set forth in Section VI.B.2.

3. To endeavor to enlist Dentists to become Participating Dentists in sufficient number to ensure an adequate choice of Dentists, and to make periodic checks as to the adequacy of care provided by Dentists to people covered by this Contract. Delta Dental is not required to provide a Dentist to an eligible person.

4. To contractually require each Participating Dentist to schedule and render all dental treatment provided under this Contract according to the standards of the dental profession in the community in which the dental procedures are rendered.

5. To make payments in the following manner for dental services provided to eligible people:

   a. If the Dentist is a PPO Dentist and a Premier Dentist, Delta Dental will base payment on the lesser of the Submitted Amount, the PPO Dentist Schedule, or the Maximum Approved Fee. Delta Dental will send payment to the PPO Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the lesser of the PPO Schedule Amount or the Maximum Approved Fee for Covered Services. The Subscriber will be responsible for the lesser of the PPO Schedule Amount, the Maximum Approved Fee, or the Dentist's Submitted Amount for most commonly-performed noncovered services. For other noncovered services, the Subscriber will be responsible for the Dentist's Submitted Amount.

**b.** If the Dentist is a PPO Dentist but is not a Premier Dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the PPO Dentist Schedule. Delta Dental will send payment to the PPO Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the PPO Schedule Amount for Covered Services. The Subscriber will be responsible for the lesser of the PPO Schedule Amount or the Dentist's Submitted Amount for most commonly-performed noncovered services. For other noncovered services, the Subscriber will be responsible for the Dentist's Submitted Amount.

**c.** If the Dentist is not a PPO Dentist but is a Premier Dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Maximum Approved Fee. Delta Dental will send payment to the Premier Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the Maximum Approved Fee for Covered Services. The Subscriber will be responsible for the lesser of the Maximum Approved Fee or the Dentist's Submitted Amount for most commonly-performed noncovered services. For other noncovered services, the Subscriber will be responsible for the Dentist's Submitted Amount.

**d.** If the Dentist does not participate in Delta Dental PPO or Delta Dental Premier, Delta Dental will base payment on the lesser of the Submitted Amount or the Nonparticipating Dentist Fee. Delta Dental will usually send payment to the Subscriber, who is responsible for making payment to the Nonparticipating Dentist. The Subscriber will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Fee.

**e.** For dental services rendered by an Out-of-Country Dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Out-of-Country Dentist Fee. Delta Dental will send payment to the Subscriber, who is responsible for making payment to the Dentist. The Subscriber will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Fee.

**6.** Consistent with any applicable law protecting the confidentiality of a patient's health records, data, or information, to make standard reports available to the Contractor upon request for no additional charge and to provide agreed-to non-standard reports on a time and materials basis.

**B. Contractor Agrees:**

**1.** To pay Delta Dental the monthly rate specified in the Declarations Section of this Contract. To ensure timely coverage, the amount to be paid will be due by the 5th of the month of the intended coverage. For example: the premium for April coverage is due on April 5th. Coverage will terminate effective the first day of the coverage month if Delta Dental receives no payment by the end of the coverage month.

Delta Dental may, at its sole option, send notification to the Contractor of an adjustment in rates, benefits, or copayments to correct potential adverse group experience resulting from the following:

**a.** Information provided upon enrollment proves to be in error; or

**b.** Terms and provisions of the Contract are violated; or

**c.** Initial size or composition of the group changes to the extent it adversely affects the rates.

Delta Dental will provide the Contractor written notice 30 days prior to implementing any adjustment. If the Contractor refuses to accept this adjustment, Delta Dental may, in its sole discretion, implement the adjustment, implement an alternative adjustment, or cancel this Contract.

2. To enroll as Subscribers with Delta Dental all eligible employees or members of the Contractor and to list, if covered, all Eligible Dependents of those employees or members, to the extent required under the Contract. The Contractor will provide Delta Dental with updates to Subscribers and, if applicable, all Eligible Dependents as necessary but no less than monthly.

3. To permit Delta Dental, by its auditors or other authorized representatives, on reasonable advance written notice, to inspect the Contractor's records to verify the accuracy of the Subscribers and Eligible Dependents submitted to Delta Dental. Clerical errors or delays in keeping or relaying data will not invalidate eligibility that would otherwise be validly in force or continue eligibility that would otherwise be validly terminated, if, after discovery of the errors or delays, an equitable adjustment of the Contractor's payments can be made in a reasonable period of time.

4. To provide each Subscriber with a privacy notice and a standard certificate of the Benefits provided under this Contract. Delta Dental will provide the privacy notice and certificate to the Contractor.

5. To collect and remit to Delta Dental any amounts that the Contractor's employees are required to pay to Delta Dental under this Contract or any written employment contracts, including amounts for COBRA continuation coverage. Any amounts not collected will be the responsibility of the Contractor.

   Should the Contractor collect any amounts paid by employees and not remit them to Delta Dental in a timely fashion, with the result that an eligible person's coverage is lost, the Contractor, not Delta Dental, will be liable for any benefits to which the eligible person may have been entitled but for the Contractor's tardy remittance or failure to remit, unless, after discovery of the errors or delays, an equitable adjustment of the Contractor's payment can be made in a reasonable period of time.

6. To pay for any agreed-to non-standard reports on a time and materials basis.

## *Section VII. General Provisions*

**A.** Dentists providing services are independent contractors, and neither the Contractor nor Delta Dental will be liable for any act or omission of any Dentist, his or her employees or agents or any person providing dental or other professional services under this Contract.

**B.** All Dentists and eligible people, by performing or receiving services under this Contract, are bound by all its terms.

**C.** Delta Dental will not honor and no payment will be made for services if a claim for those services has not been received by Delta Dental within one year following the date the services were completed.

**D.** No materials will be published or distributed by the Contractor concerning this Contract until Delta Dental approves the materials.

E. No action on a legal claim arising out of or related to this Contract will be brought until 30 days after notice of the legal claim has been given to Delta Dental. In addition, no action can be brought more than three years after the legal claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim.

F. Delta Dental and Contractor agree to defend, indemnify and hold harmless the other and its directors, officers and employees (who are acting in the course of their employment, but not as claimants) from any loss, cost, or expense (including reasonable attorney fees and court costs) resulting from or arising out of or in connection with its breach of this Contract or any negligent act or omission of any of its directors, officers or employees unless liability for such act or omission is expressly assigned elsewhere in this Contract.

G. While an eligible person is covered by Delta Dental, that person agrees to provide Delta Dental with any information it needs to process the claims and administer the Benefits. This includes allowing Delta Dental to have access to his or her dental records.

H. Delta Dental will establish procedures for resolving all questions raised by a Dentist, a Contractor, or an eligible person in regard to claims for dental benefits allowed or rejected under the terms of this Contract. These procedures will be used both for the initial determination of those questions and for the resolution of appeals made on the basis of those initial determinations. The procedures established for determining the entitlement and amount of benefits to which eligible people are entitled under any benefit plan sponsored by the Contractor that is regulated under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, will comply with ERISA Section 503, and the regulations thereunder for providing a "full and fair review" of all benefit claims.

The ERISA-required claims procedures will be set forth in detail in the certificate that is to be distributed to eligible people and that describes the dental benefits under this Contract. All determinations made according to this procedure will be final and binding on the Dentist, the Contractor, and the eligible person; provided, however, that the eligible person may exercise his or her legal rights after this determination as described in the Claims Appeal Procedure.

I. All of the Benefits under this Contract are subject to a coordination of benefits provision, if applicable, that is designed to provide maximum coverage, but not to exceed 100 percent of the fee for a given treatment.

**1. Applicability**

**a.** This coordination of benefits (COB) provision applies to this Plan when a person has health care coverage under more than one plan.

**b.** If this COB provision applies, the Order of Benefit Determination Rules below determine whether the benefits of this Plan are determined before or after another plan. This Plan's benefits:

**(1)** Will not be reduced when this Plan determines its benefits before another plan; but

**(2)** May be reduced when another plan determines its benefits first. This reduction is described in "Effect on the Benefits of This Plan".

**2. Definitions:**

**a.** A plan is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

(3) Plan does not include school accident-type coverage, individual contracts of coverage, or some supplemental sickness and accident policies.

Each contract or other arrangement for coverage under **(1)** or **(2)** is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

**b.** This Plan is the part of this group Contract that provides benefits for health care expenses.

**c.** The Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan when a person is covered by more than one plan.

When this Plan is a Primary Plan, its benefits are determined before the other plan and without considering those benefits.

When this Plan is a Secondary Plan, its benefits are determined after the other plan's benefits and may be reduced because of those benefits.

When a person is covered under more than two plans, this Plan may be a Primary Plan as to one or more of those plans and may be a Secondary Plan as to the other plans.

**d.** Allowable Expenses are necessary, reasonable, and customary items of expense for health care when they are covered by this Plan. However, this Plan is not required to pay for an item, service, or benefit which is not a part of this Plan's contract.

When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an allowable expense and benefit paid.

**3. Order of Benefit Determination Rules**

**a.** This Plan is a Secondary Plan whose benefits are determined after those of other plans, unless:

(1) The other plan has rules coordinating its benefits with this Plan; and

(2) Both those rules and this plan's rules, in subsection below, require that this Plan's benefits be determined before the other plan's benefits.

**b.** This Plan determines its order of benefits using the first of the following rules which applies:

(1) The benefits of the plan which covers the person as an employee or Subscriber (that is, other than as a dependent) are determined before the benefits of the plan which covers the person as a dependent. However, this rule does not apply if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

**(a)** Secondary to the plan covering him or her as a dependent and

**(b)** Primary to the plan covering him or her as other than a dependent (for example, a retired employee).

**(2)** Benefits for a dependent child whose parents are not separated or divorced shall be determined as follows:

**(a)** The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but

**(b)** If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered them for a shorter period of time.

However, if the other plan does not have the rules described in **(a)** above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the other plan's rule will determine the order of benefits.

**(3)** Benefits for a dependent child whose parents are separated or divorced shall be determined as follows to the extent the plan has received a copy of the court decree:

**(a)** If the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent shall be the Secondary Plan.

**(b)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall be subject to the order of benefit determination contained in subdivision **(2)** of this section.

If neither subdivision **(a)** nor **(b)** applies, the order of benefits shall be determined in the following order:

**(a)** The plan of the parent with custody of the child;

**(b)** The plan of the spouse of the parent with custody of the child;

**(c)** The plan of the parent without custody of the child; and

**(d)** The plan of the spouse of the parent without custody of the child.

If the other plan does not have this subsection, and if, as a result, the plans do not agree on the order of benefits, this subsection will be ignored.

**(4)** The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as his or her dependent) are determined before the benefits of a plan which covers that person as a laid-off or retired employee (or as his or her 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 paragraph shall be ignored.

**(5)** If a person is covered under another plan that is provided under a right of continuation pursuant to federal law (that is, COBRA) or state law, the benefits of the plan covering him or her as an employee or a Subscriber (or as his or her dependent) will be determined before the benefits under the continuation coverage.

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 paragraph will be ignored.

(6) If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee or a Subscriber longer are determined before the benefits of the plan which covered him or her for the shorter term.

**4. Effect on the Benefits of This Plan**

**a.** This section applies when, in accordance with section "Order of Benefit Determination Rules," this Plan is a Secondary Plan as to another plan. In that event, this Plan's benefits may be reduced under this section.

**b.** This Plan's benefits will be reduced to the extent that the sum of:

(1) The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of similar provisions, whether or not claim is made, exceeds those Allowable Expenses. In that case, this Plan's benefits will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When this Plan's benefits are reduced as described above, it is then charged against any applicable benefit limit of This Plan.

**5. Right to Receive and Release Needed Information**

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person, subject, in all events, to all provisions of applicable law.

Delta Dental need not tell or get the consent of any person to do this. Each person claiming benefits under this Plan must give Delta Dental any facts it needs to pay the claim.

**6. Facility of Payment**

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Delta Dental may pay that amount to the organization that made the payment.

That amount will be treated as though it were a benefit paid under this Plan and Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

**7. Right of Recovery**

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of:

**a.** The persons it has paid or for whom it has paid;

**b.** Another plan; or

**c.** The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

**J.** Delta Dental may from time to time provide additional services or benefits by rider or other notice. Delta Dental may withdraw those services or benefits at any time after giving notice.

**K.** Any notice required or permitted to be given by Delta Dental will be considered given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the Contractor, a Dentist, or a Subscriber at the last address of record. This notice will be considered given when personally delivered or mailed.

**L.** No agent has authority to change any part of this Contract. No changes to this Contract will be valid unless Delta Dental approves them in writing. Delta Dental shall have the discretion to assign its rights and responsibilities under this Contract to an affiliated entity. If Delta Dental chooses to assign its rights and responsibilities, it shall assign them to an appropriately licensed entity capable of performing similar functions at similar levels as Delta Dental. Delta Dental shall serve written notice of the assignment to Contractor and said notice shall provide the name and address of the assignee. Neither this Contract nor any part of it shall be assigned by Contractor without the prior written consent of Delta Dental, and any attempt at assignment by Contractor without such consent by Delta Dental shall be null and void. Subject to the foregoing limitation, this Contract shall be binding upon the parties and their respective successors and assigns.

**M.** Subrogation and Right of Reimbursement: To the extent that the Plan provides or pays benefits for Covered Services, Delta Dental is subrogated to any right the Subscriber may have to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. The Subscriber or his or her legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them. If the Subscriber recovers damages from any party or through any coverage named above, the Subscriber must reimburse Delta Dental from that recovery to the extent of payments made under the Plan.

**N.** Right of Recovery Due to Fraud: If Delta Dental pays for dental services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to the acts of the Contractor, Subscriber and/or Eligible Dependent, it may recover that payment from the Contractor, Subscriber and/or Eligible Dependent. Contractor, Subscriber and/or Eligible Dependent authorizes Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to the Contractor, Subscriber and/or Eligible Dependent. Delta Dental will provide an explanation of the payment being recovered at the time the deduction is made.

**O.** Force Majeure: Neither Delta Dental (including its agents, directors, officers, and employees) nor Contractor shall be liable for delays in performance due to circumstances beyond their reasonable control. Each party shall be excused from performance under this Agreement and shall have no liability to the other party for any period that it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications, and such nonperformance shall not be a default under or grounds for termination of this Agreement.

**P.** Services and/or benefit payments to eligible people are for the personal benefit of those people and cannot be transferred or assigned; provided, however, that Delta Dental may pay Participating Dentists directly on behalf of eligible people.

**Q.** The group Contract and/or certificate will be governed by and interpreted under the laws of the state of Ohio.

**R.** Legally Mandated Benefits: If any applicable law requires broader coverage or more favorable treatment for the Subscriber or an Eligible Dependent than is provided by this Contract, that law shall control over the language of this Contract.

**S.** Right of Recovery Due to Overpayment: If Delta Dental determines that it has, for any reason, paid a Dentist more for dental services than is provided for under this Contract (the "Overpayment Amount"), Delta Dental has the right to recover the Overpayment Amount from the Dentist to which the Overpayment Amount was made. Delta Dental will provide the Dentist with notice of the Overpayment Amount, and the basis on which Delta Dental believes that the payment made was in excess of the amount properly due under the Contract, and will request that the Overpayment Amount be returned to Delta Dental. Should the Dentist return the Overpayment Amount, Delta Dental's right of recovery will have been satisfied. Should the Dentist fail to return the requested Overpayment Amount, Delta Dental reserves the right to offset the Overpayment Amount from any future payments due that Dentist for dental services insured by Delta Dental. Where Overpayment Amounts are recovered by means of an offset, the Overpayment and Offset Amounts will be properly credited to, or debited from, the affected Dental Plan(s) so that all involved Dental Plans will have been administered according to their terms and will have paid only the amount that is properly payable for the dental services provided.

## *Section VIII. Term and Termination*

This Contract shall remain in full force and effect for the initial term and any renewal term of this Contract as specified in the Declarations Section of this Contract or in an evergreen renewal letter. Delta Dental shall have the option of terminating this Contract if:

**A.** The Contractor fails for more than 30 days to make a required payment; or

**B.** Delta Dental elects to cancel pursuant to Section VI.B.1. of this Contract; or

**C.** The Contractor fails to furnish Delta Dental with accurate enrollment data pursuant to Section VI.B.2.; or

**D.** The Contractor permits voluntary enrollment of Subscribers and/or their dependents unless otherwise specified in the Declarations Section; or

**E.** The Contractor voluntarily wishes to cancel this Contract and provides Delta Dental with 30 days' written notice of intent to cancel; or

**F.** The Contractor refuses to allow Delta Dental (by Delta Dental's auditors or other authorized representatives) to inspect the Contractor's records to verify the accuracy of eligible Subscribers and Eligible Dependents pursuant to Section VI.B.3.; or

**G.** The Contractor has otherwise breached this Contract.

## *ACCEPTED:*

**DELTA DENTAL PLAN OF OHIO, INC.**

**BY:** _____
President and CEO

**DATE:** **January 13, 2012**

**CONTRACTOR**

**BY:** _____
(Authorized Signature)

_____
(Title)

**BY:** _____
(Witnessed By)

_____
(Title)

**DATE:** _____