

PENDING APPROVAL

REQUISITION SHEET MUST BE ATTACHED

(Applies when agenda item requires a specific payment)

OKLAHOMA COUNTY BUDGET BOARD OF OKLAHOMA COUNTY

AGENDA ITEM REQUEST SHEET

For the: May 20, 2010 Agenda
(Day of Meeting) (Date and Year of Meeting)

DEPT.: County Clerk's HR/Benefits Dept. BY: Jon Wilkerson forCarolynn Caudill, County Clerk EXT. 1535
(Department Requesting this item) (Contact person for this Item) (Contact's extension)

NAME OF FUND: Employee Benefits 4010

AGENDA ITEM DESCRIPTION: Discussion and possible action for approval of the Administrative Services Agreement renewal between Delta Dental Plan of Oklahoma and Oklahoma County. Oklahoma County will continue to pay an Administrative Fee of 6% of paid claims per month & a Cost Containment Fee of not more than 4%. This Agreement shall commence on July 1, 2010 and terminate on June 30, 2011. Requisition No. 11006465 has been issued to Delta Dental in the amount of \$77,859.00 from Employee Benefits Fund 4010 contingent upon encumbrance of funds. Requested by Carolynn Caudill, County Clerk and Secretary to the Budget Board of Oklahoma County and approved as to form and legality by John Jacobsen, Assistant District Attorney.

(ALL NECESSARY DOCUMENTATION MUST BE ATTACHED FOR APPROVAL)

APPROVED BY D.A
(If Applicable)

APPROVED BY PURCHASING
(If Applicable)

Assistant District Attorney

Purchasing Agent

APPROVED BY MIS
(If Applicable)

APPROVED BY ENGINEER
(If Applicable)

MIS Director

County Engineer

Number of ORIGINAL DOCUMENTS you have attached: 1. NOTE: The County Clerk will keep one original and will return the remaining originals to you. If you provide only one original, the Board Secretaries will return one photocopy to you. However, if you have special circumstances that require the County Clerk to (check one): _____ keep more than one original; or _____ return all originals to you, please describe them for the County Clerk's consideration: _____

Special Instructions: _____

OKLAHOMA COUNTY INCOMPLETE REQUISITIONS REPORT

DATE PRINTED--: 04-28-2010

Requisition No--: 11006465
Requisition Type--: Purchase Requisition
Creation Date--: 04-28-2010
Description--: Dental claims administration and cost containment fees

Requestor Holt, Bradford C
Qty/Amt 78,859 Unit Price \$ 1.00 Line Amt \$78,859.00 Category SERVICE FEES
Item Description: Administration and cost containment fees for dental claims for FY2011.

Vendor: DELTA DENTAL PLAN OF OKLAHOMA INC Distribution: ...

Requisition Total: \$78,859.00

Approval Action (Circle One)

Approve Forward Reject

Forward To : _____

Note : _____

Signature: _____

OKLAHOMA COUNTY INCOMPLETE REQUISITIONS REPORT

DATE PRINTED--: 04-28-2010

Requisition No--: 11006465
Requisition Type--: Purchase Requisition
Creation Date--: 04-28-2010
Description--: Dental claims administration and cost containment fees

Requestor Holt, Bradford C Qty/Amt Unit Price Line Amt Category

78,859 \$ 1.00 \$78,859.00 SERVICE FEES
Item Description: Administration and cost containment fees for dental claims for FY2011.

Vendor:DELTA DENTAL PLAN OF OKLAHOMA INC Distribution: ...

Requisition Total: \$78,859.00

Approval Action (Circle One)

Approve Forward Reject

Forward To : _____

Note : _____

Signature: _____

PENDING APPROVAL

ADMINISTRATIVE SERVICES AGREEMENT

This Agreement, sometimes referred to as the Plan, made and entered into effective July 1, 2010, by and between **Oklahoma County**, hereinafter referred to as Plan Sponsor and/or Plan Administrator, and **Delta Dental Plan of Oklahoma**, an Oklahoma nonprofit dental service corporation with its corporate offices in Oklahoma City, Oklahoma, hereinafter referred to as DDPOK and/or Claims Administrator, is as hereafter provided.

WHEREAS the Plan Administrator has established a self-insured Benefit Plan to provide for certain classes of Employees (and their eligible Dependents, if applicable), as identified in Appendix A attached and forming a part of this Agreement by reference herein, under which DDPOK will provide benefits to which they are entitled; and

WHEREAS DDPOK is willing to provide Benefits for that purpose under the terms and conditions set forth herein and in Appendix A attached and forming a part of this Agreement;

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and conditions herein contained, Oklahoma County and Delta Dental Plan of Oklahoma agree to the terms and conditions hereinafter set forth.

Section 1. Administrative Fee

The Administrative Fee for the contract period commencing July 1, 2010, shall be Six Percent (6%) of Paid Claims per month, subject to the provisions of DDPOK's Cost Containment Guarantee set forth in Section 3.F. of this Agreement. "Paid Claims" shall mean the claims payment amounts for claims by Covered Persons for Benefits for which the Plan Administrator is liable under the provisions of this Agreement and excludes the amount of such claims for which the Covered Persons are liable. Notification, payment, or modification of such administrative fee shall be as follows in this Section, in Section 3.F., and in Sections 5.A. and 5.E. of this Agreement:

- A. DDPOK will bill Plan Administrator the monthly administrative fee by the fifth (5th) day of each month.
- B. Plan Administrator will remit payment for the monthly administrative fee to DDPOK within twenty (20) days of receipt of such billing.

Section 2. Plan Administrator Responsibilities

Plan Administrator agrees:

- A. To furnish to DDPOK an accurate statement of the total number and names of all Eligible Persons to the group (and their Dependents, if covered) who are eligible to receive dental Benefits hereunder commencing on July 1, 2010, and monthly thereafter to furnish DDPOK with additions and deletions to such list on forms provided by DDPOK or in a form and format mutually agreeable to Plan Administrator and DDPOK.
- B. When reporting Eligible Person and Dependent eligibility in an electronic format (file or on-line), to report such data in the established, agreed format.

PENDING APPROVAL

- L. To treat with the highest degree of confidentiality all information compiled and reported to Plan Administrator by DDPOK and identified therein as confidential, including but not limited to statistical and actuarial information and claims procedure manuals.

Section 3. DDPOK Responsibilities

DDPOK agrees:

- A. To provide dental benefits to Covered Persons in accordance with the Plan design set forth in Appendix A attached and forming a part of this Agreement and any amendments thereto which are hereafter approved in accordance with Section 4 and Section 5 of this Agreement.
- B. To be responsible for timely and properly paying all claims for which it receives funds from the Plan Administrator pursuant to Section 2.D. of this Agreement and for all claims administration services related to the delivery of dental Benefits under the provisions of this Agreement. "Timely and proper payment of claims" and "timely and properly paying all claims", as stated herein in this Agreement, shall be based on provisions of the DDPOK performance guarantees set forth in Section 3.E.1. and Section 3.E.2. of this Agreement.
- C. To make available to Plan Administrator such utilization statistics and actuarial information compiled and retained by DDPOK which Plan Administrator and DDPOK agree to be reasonable for reporting purposes.
- D. To issue any billing, notification, payment, and/or report in compliance with the requirements set forth in this Agreement.
- E. To implement the following performance standards and guarantees and reimburse the Plan Administrator an amount of the administrative charge, as outlined below, should DDPOK's performance for the contract period fall below the level outlined herein:
 - 1. Annual Claims Accuracy Performance Guarantee: DDPOK guarantees financial accuracy (correct dollars paid) of ninety-nine percent (99%) and procedural accuracy (claims entry/data entry) of ninety-seven percent (97%) for claims paid during each twelve (12) consecutive month period, beginning January 1 and continuing through and including December 31 each year so long as the Administrative Services Agreement remains in effect or until modified by agreement of the parties. DDPOK will draw a random sample of claims from total dental claims paid during the twelve (12) consecutive month review period. From this sample of claims, DDPOK will measure financial and procedural accuracy, and report to Plan Administrator annually. Financial accuracy will be determined by dividing the total dollar amount paid in error by the total dollar amount paid for claims included in the annual sample. Procedural accuracy will be determined by dividing the number of errors, or combination of errors, in data entry by the total number of claims in the annual sample. DDPOK will reimburse Plan Administrator \$100 for each percentage point financial accuracy and/or procedural accuracy fall below the percentages guaranteed for each. The maximum reimbursement for failure to satisfy the financial and/or procedural guarantee shall be \$500 per twelve (12) consecutive month review period. Any penalty DDPOK is required to pay for failure to perform at the guaranteed financial and/or procedural accuracy level will be based on the annual measurement performed following the end of the twelve (12) consecutive month review period.

PENDING APPROVAL

3. Should savings generated in the stated categories exceed the administrative fee set forth in Section 1 of this Agreement, Plan Administrator will reimburse DDPOK an amount equal to one-half of the savings generated in excess of the administrative fee set forth in Section 1 of this Agreement, not to exceed a maximum administrative fee of Ten Percent (10%) of paid claims.
 4. Fifteen (15) months from the effective date of the Plan Agreement between DDPOK and Oklahoma County, DDPOK will compute the total savings generated in the stated categories during the first twelve (12) months of such Plan Agreement, at which time a settlement will be made.
 5. A savings settlement covering any subsequent twelve (12) month contract period of this Agreement will occur at twelve (12) month intervals following the initial settlement. Such settlement(s) will be based on the guidelines set forth above or such other guidelines agreed to by Plan Administrator and DDPOK.
- G. To endeavor to enlist Dentists to become Participating Dentists in sufficient number to ensure adequate choice of Dentist.
 - H. To provide professional review of the adequacy and appropriateness of services rendered by Dentists.
 - I. To encourage each Dentist to schedule and render all dental treatment provided in this Plan in accordance with applicable standards of the dental profession in his or her community.
 - J. To encourage Participating Dentists to complete and submit for predetermination of benefits a standardized Attending Dentist Statement (claim form) prior to rendition of service, except for emergency services or brief routine services, indicating the Eligible Person's or Eligible Dependent's dental needs and treatment necessary in the professional judgment of the Dentist and to notify the Eligible Person or Eligible Dependent of all actions taken by Delta with respect to such Attending Dentist Statement.
 - K. To issue an estimate of benefits regarding the Attending Dentist Statement when satisfied that the patient is eligible hereunder. Such predetermination by DDPOK shall be for a maximum period of three hundred sixty-five (365) days from the date of predetermination by DDPOK (one hundred eighty [180] days for periodontal procedures), but no longer than the period of this Agreement as stated in Section 5.
 - L. To make no payments from the moneys received from the Plan Administrator for any services rendered to a patient who is not eligible at the time of rendition of the service, subject to the provisions of Section 2.I. and Section 4.F. of this Agreement.
 - M. To issue an explanation of benefits regarding services rendered an eligible person and make payment of that portion of the fee for which the Plan is liable in accordance with this Agreement. Such payment, together with the Eligible Person's or Eligible Dependent's portion of the fee required, shall discharge the claim of a Participating Dentist.
 - N. When dental services are performed or provided by a properly licensed dentist, to provide benefits to eligible Subscribers and eligible Dependents for the dental services listed in Appendix A

PENDING APPROVAL

H. Claim and Appeal Processing and Procedures.

1. Emergency Care.

This Plan does not require any preauthorization for any dental services (including emergency care); however, said services are subject to the plan's specific limitations, non-covered charges, deductibles, and co-payment amounts, as well as any charges over the plan maximum as defined in Appendix A.

2. Request for Predetermination of Benefits.

If the cost estimate of a dental procedure is more than \$150 and the treatment is not emergency care, the dentist can determine the treatment needed and submit a treatment plan to DDPOK for predetermination of benefits. This procedure will enable a Subscriber or dependent and the dentist to know in advance of treatment what services are covered, how much of the cost will be paid by this Plan, and how much of the cost will be the responsibility of the Subscriber or dependent.

3. Filing a Claim.

Whether the Subscriber or dependent is treated by a dentist who is a Delta Dental participating dentist, or is not a Delta Dental participating dentist, the filing forms and procedures shall be the same, as defined in the Claim and Appeal Procedure.

Once treatment is completed, the Subscriber, dependent, or designated personnel in a dental office must complete the information portion of the claim form with the Subscriber's full name, Subscriber's social security number, the name and date of birth of the person receiving dental care, and the group name and number.

All claims must be submitted to Delta Dental Plan of Oklahoma at the assigned address.

The Plan is not obligated to pay any claim submitted later than twelve (12) months following the date of service.

Participants and beneficiaries can obtain from DDPOK, without charge, the necessary claim filing forms.

4. Explanation of Benefits.

Once DDPOK has received the claim form, and all necessary information, a copy of an Explanation of Benefits will be sent to the Subscriber by DDPOK within a reasonable time, but no later than thirty (30) days after receipt of a claim. DDPOK may extend this time period one time up to fifteen (15) days, prior to the expiration of the thirty (30) day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Subscriber will be given forty-five (45) days from receipt of the notice within which to provide the necessary information.

PENDING APPROVAL

No action at suit of law or equity shall be commenced upon or under this Agreement until thirty (30) days after notice of claim has been given to DDPOK, nor shall action be brought at all later than three (3) years after such claim has arisen.

- I. DDPOK shall have no liability under this Agreement for benefits required to be paid from the Plan Administrator's funds. The Plan Administrator shall have no liability for benefits required to be paid from DDPOK funds. It is agreed that the benefits paid from the funds of the Plan Administrator and DDPOK are, and shall be, mutually exclusive.
- J. Each party shall notify the other of any third party claims coming to its attention that could result in a claim for indemnification by the other party under Section 2 or Section 3 of this Agreement. The other party may, by waiving all its rights to contest indemnifying the notifying party for any potential loss, damage, or expense resulting from such claim, direct and control the resolution of such claim by litigation or otherwise, including full power to settle such claim in a commercially reasonable manner; provided, however, that the notifying party shall have the right to participate in resolution of the claim, at its own expense, by selecting co-counsel.
- K. Any notice required or permitted to be given by the Plan Administrator or DDPOK hereunder shall be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the Plan Administrator or DDPOK at the address listed below; such notice shall be deemed to be given when so personally delivered or three (3) days after having been placed in the United States mail, postage prepaid, return receipt requested. Any party shall have the right to designate a different address or agent for the receipt of notice by providing notice of such designation in the manner set forth herein.
 - 1. Oklahoma County
320 Robert S. Kerr
Oklahoma City, Oklahoma 73102
 - 2. Delta Dental Plan of Oklahoma, Inc.
Mr. John E. Gladden
President and Chief Executive Officer
16 Northwest 63rd Street, Suite 201
Oklahoma City, Oklahoma 73116-9115
- L. During the term of this Agreement, any premium taxes enacted and levied on DDPOK by the state or federal government with respect to benefits provided and/or administrative fees charged pursuant to this Agreement will be passed on to the Plan Administrator, but will remain the liability of DDPOK.
- M. A copy of any materials published or distributed by Plan Administrator concerning this Agreement and the benefits hereunder shall be furnished to the Claims Administrator.
- N. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the Plan Administrator or DDPOK other than that of independent contractors.
- O. All statements made by the Plan Administrator, DDPOK, or by an individual shall be deemed representations and not warranties. No such statement shall be used in defense to a claim under this Plan unless it is contained in a written application.

PENDING APPROVAL

- Y. Should the Plan Sponsor fail to fund the account as described hereinabove within twenty (20) days of notification from DDPOK to the Plan Administrator of the amount necessary to properly fund the payments to cover the expenditures made on behalf of the Plan Sponsor, DDPOK shall be absolved of all liability to provide further administration of the group dental plan and shall be entitled to reimbursement with interest at the rate of ten percent (10%) for each month payment due is withheld. DDPOK shall have no obligation to pay such claims from its own funds.
- Z. The Delta Dental Signature, consisting of the Delta Symbol and the Delta Dental Logotype, and the Delta Dental Product/Program Signatures are the exclusive property of Delta Dental. Plan Administrator and/or Plan Sponsor shall not utilize such Signatures in published material of any type without the express written consent of Delta Dental.

Section 5. Term and Termination

- A. This Agreement shall remain in full force and effect for a term of twelve (12) months, or through June 30, 2011. The parties understand and agree that this Agreement may not be automatically renewed, however, the parties may agree to contract for successive one-year terms, or for such shorter term(s) as the parties agree, with any amendments thereto, but such re-contracting must be approved each year by the Board of County Commissioners of Oklahoma County. Plan Administrator agrees to notify DDPOK, in writing, on or before the anniversary date of this Agreement, of intent to contract with DDPOK for a successive one-year term or for such shorter term as the parties agree. Anniversary Date shall mean July 1, 2011.

In the event that DDPOK determines a change in the administrative fee, benefit design, and/or other terms of this Agreement are necessary effective on the Anniversary Date, advice of such proposed changes must be given to the Plan Administrator, in writing, no less than sixty (60) days prior to such Anniversary Date. Should Plan Administrator and DDPOK agree to contract for a successive one-year term, or for such shorter term as the parties agree, the plan agreement for such successive term shall be issued and mailed to the Plan Administrator at least forty-five (45) days in advance of the Anniversary Date of this Agreement.

- B. This Agreement shall automatically terminate as of the earliest of the following dates:
 - 1. The date on which the Plan Administrator shall not have made funds available for the payment of all Benefits required to be paid from its funds in accordance with this Agreement; or
 - 2. The date on which the Plan Administrator discontinues payment of the monthly administrative fee.
- C. If either party otherwise fails to observe or perform any of its obligations under this Agreement and if the failure continues for a period of thirty (30) days after written notice thereof to the defaulting party, then without prejudice to any other rights or remedies the other party may have, this Agreement will terminate as of the expiration date of the notice period.
- D. Either party may immediately suspend all or any part of its obligations under this Agreement and/or immediately terminate this Agreement upon written notice if the other party becomes or is declared insolvent or bankrupt or becomes the subject of any proceedings related to its liquidation, insolvency, or for the appointment of a receiver or similar officer for it. Any such suspension of performance will not be a breach of this Agreement and will not affect the suspending party's right to pursue or enforce any of its rights under this Agreement or otherwise.

PENDING APPROVAL

Section 6. Force Majeure

It is expressly understood by both parties that Oklahoma County shall be relieved of any liability in the event that a part of this agreement cannot be performed due to causes which are outside the control of the parties and could not be avoided by exercise of due care.

IN WITNESS WHEREOF, the Plan Administrator and DDPOK have caused this Agreement to be executed to be effective July 1, 2010, as evidenced by their signatures and those of the Board of County Commissioners of Oklahoma County below:

OKLAHOMA COUNTY

DELTA DENTAL PLAN OF OKLAHOMA

By: _____

By: *K. D. Sullivan*

Title: _____

Title: Vice President of Sales & Marketing

Attest: _____

Attest: *[Signature]*

Date: _____

Date: April 8, 2010

Approved this ___ day of _____, 2010, by the BOARD OF COUNTY COMMISSIONERS OF OKLAHOMA COUNTY.

BOARD OF COUNTY COMMISSIONERS

Chairman

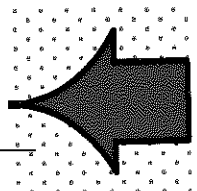
Member

Member

ATTEST: _____

Carolynn Caudill, County Clerk

[Signature]
Approved as to form and legality:
4/26/2010
Assistant District Attorney



Attachments: Appendix A

PENDING APPROVAL

APPENDIX A

OKLAHOMA COUNTY

EFFECTIVE JULY 1, 2010

PENDING APPROVAL

SECTION 1 - DEFINITIONS

1. **ACTIVELY AT WORK:** The active expenditure of time and energy in the services assigned by the Employer. An Employee shall be deemed to be Actively at Work on each day of a regular paid vacation, an Employer holiday, or on a regular nonworking day, if such Employee is not disabled and was Actively at Work on the work day preceding his or her Effective Date.
2. **ALLOWABLE CHARGE:** The charge the Claims Administrator will use as the basis for Benefit determination for Covered Services Incurred by a Covered Person under this Plan. The Claims Administrator will use the following criteria to establish the Allowable Charge:
 - a. **Delta Dental PPO Participating Dentists** - the Dentist's submitted fee up to the amount the Delta Dental PPO Participating Dentist has agreed to accept as payment for Covered Services in accordance with a Delta Dental PPO Participating Dentist Agreement.
 - b. **Delta Dental Premier Participating Dentists** - the Dentist's submitted fee up to the maximum allowable amount the Delta Dental Premier Dentist has agreed to accept as payment for Covered Services in accordance with a Delta Dental Premier Participating Dentist Agreement.
 - c. **Nonparticipating Dentists** - the Nonparticipating Dentist's submitted fee up to the amount the Claims Administrator determines to be the Prevailing Fee in the specific geographic area where the Covered Services were rendered.
3. **BENEFIT PERIOD:** The specified period of time during which charges for Covered Services must be Incurred to be eligible for payment under the Plan. For purposes of this Plan, benefit period shall mean the twelve (12) month period commencing January 1 and continuing through and including December 31 each year.
4. **BENEFITS:** The payment, reimbursement, or indemnification of any kind for those Dental Services which are made available to Covered Persons under the terms of the Plan and which are listed as part of this Plan Document.
5. **CALENDAR YEAR:** The period of 12 months commencing on the first day of January and continuing through the last day of December.
6. **CLAIMS ADMINISTRATOR:** Delta Dental Plan of Oklahoma, a nonprofit dental service corporation, with its main office in Oklahoma City, Oklahoma.
7. **CONTINUATION COVERAGE (COBRA):** Coverage under the Plan for a Covered Person with respect to whom a Qualifying Event has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Plan to Covered Persons with respect to whom a Qualifying Event has not occurred.
8. **COPAYMENT:** The amount the Covered Person is required to pay in addition to the Plan's payment.

PENDING APPROVAL

20. **EXPERIMENTAL/INVESTIGATIONAL:** A drug, device, or dental treatment or procedure is experimental/investigational if:
- a. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
 - b. Reliable Evidence shows that:
 - 1) the drug, device, or dental treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
 - 2) the consensus among appropriately qualified consultants of the Plan regarding the drug, device, or dental treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment.

“Reliable Evidence” shall mean only: a) published reports and articles in the authoritative medical, dental, and scientific literature; b) the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or dental treatment or procedure; or c) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or dental treatment or procedure.

21. **FAMILY COVERAGE:** Coverage for the Employee and one or more of the Employee’s Eligible Dependents.
22. **FULL-TIME STUDENT:** A person who is a registered student in regular full-time attendance at an accredited secondary school, college, or university. A person is considered to be in full-time attendance if he or she is enrolled for credit in a course of study in 12 or more semester hours, or as defined by the college or university.

Upon completion of the spring school term, eligibility shall be extended during the summer months provided the student has pre-enrolled for the following semester of study. Proof of eligibility is the responsibility of the Eligible Person.

23. **GROUP:** Group consists of all Covered Persons eligible to receive Dental Services hereunder.
24. **INCURRED:** An expense is Incurred on the date a Covered Person receives the service or supply for which the charge is made.
25. **MEDICAL CHILD SUPPORT ORDER (MCSO):** Any judgment, decree, or order issued by a court of jurisdiction made pursuant to a state domestic relations law or which enforces a law relating to medical child support under Medicaid. Documentation of such order may be supplied to a group health plan by a custodial parent, State Department of Health Services, or the district attorney in whose jurisdiction the child resides.
26. **PLAN:** This Plan of Benefits for dental care and services provided by and through the Employer.

PENDING APPROVAL

- d. The covered Employee becoming entitled to benefits under Medicare;
 - e. A dependent child ceasing to be eligible.
37. **SINGLE DENTAL PROCEDURE:** A dental procedure listed in the Uniform Procedure Code and Nomenclature of the American Dental Association.
38. **TOTALLY AND PERMANENTLY DISABLED:** A condition resulting from disease or injury in which, as certified by a Physician:
- a. the Covered Person is unable to perform the substantial duties of any occupation or business for which qualified and is not in fact engaged in any occupation for wages or profit; or
 - b. if the Covered Person does not usually engage in any occupation for wages or profit, the Covered Person is substantially unable to engage in the normal activities of an individual of the same age and sex.

PENDING APPROVAL

2. The limiting age for a Dependent child is:
 - a. the date on which such child attains the age of nineteen (19); or
 - b. the date on which such child attains the age of twenty-five (25) if regularly attending an accredited school, college, or university as a Full-Time Student.
 - c. An Eligible Person's unmarried child who is incapable of self-support because of mental retardation or physical incapacity is eligible to continue coverage beyond the limiting age, provided a physician's certificate of such incapacity and dependence on the Eligible Person is submitted within six (6) months of said mental retardation or physical incapacity, the effective date of this Plan, or the effective date of said Dependent child's coverage, whichever is later.
 - d. The Plan Administrator reserves the right to request verification of a Dependent child's age, dependency, and/or status as a Full-Time Student or disabled Dependent child upon initial enrollment and from time to time thereafter as the Plan may require.
3. An Eligible Dependent may not be covered as a Dependent of more than one Employee.

D. EFFECTIVE DATE

1. If a person is an Eligible Person on the Plan Effective Date and his or her application for Employee Only or Family Coverage is received by the Plan Administrator at that time, the Effective Date of coverage is the Plan Effective Date.
2. If a person becomes an Eligible Person after the Plan Effective Date and his or her application for Employee Only or Family Coverage is received by the Plan Administrator within thirty-one (31) days of first being eligible, the Effective Date of coverage will be the first of the month following Plan Administrator approval of the completed application.
3. An Eligible Person can change from Employee Only coverage to Family Coverage if application is received by the Plan Administrator within thirty-one (31) days after the Eligible Person acquires an Eligible Dependent. The Effective Date of coverage for the Eligible Dependent will be the first of the month following Plan Administrator approval of the completed application.
4. An Eligible Person with Family Coverage can add additional Eligible Dependents if application is received by the Plan Administrator within thirty-one (31) days after the Eligible Person acquires the additional Eligible Dependent. The Effective Date of coverage for the additional Eligible Dependent will be the first of the month following Plan Administrator approval of the completed application.
5. A child under a Qualified Medical Child Support Order (QMCSO) may be added to an Eligible Person's coverage provided the Plan Administrator receives the Medical Child Support Order (MCSO) within thirty-one (31) days of the date it is issued and such MCSO is determined by the Plan Administrator to be a QMCSO. The Effective Date for such child will be the date ordered by the court.

PENDING APPROVAL

is eligible for coverage under this group plan. Eligibility determinations will be made in accordance with federal and/or state child support order laws and regulations. The Employee will be responsible for any contributions required under this plan.

The coverage provided in accordance with a qualified medical child support order will be effective as of the date of the child support order and subject to all provisions of the plan except:

1. A qualified dependent may be covered without personal coverage in effect under the group plan.
2. In addition to the reasons for termination of coverage shown in the Termination of Coverage provision, the coverage required by a qualified medical child support order will cease on the earlier of the date the support order expires or the date the dependent is enrolled for similar coverage.

Under this provision, if covered expenses for a dependent child are paid by a custodial parent or legal guardian who is not a plan member, benefits payable will be remitted directly to the custodial parent or legal guardian rather than the plan member or eligible employee. A custodial parent or legal guardian may also sign claim form and assign plan benefits, if assignable.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan, with no Pre-existing Conditions provisions applied.

F. CONTINUATION COVERAGE (COBRA)

1. Eligibility for Continuation Coverage

When a Qualifying Event occurs, eligibility under this Plan shall continue for the Eligible Person and/or his or her Eligible Dependents who were covered on the date of the Qualifying Event for a period not to exceed:

- a. eighteen (18) months from the date of a Qualifying Event involving the termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment; or
- b. thirty-six (36) months from the date of a Qualifying Event involving the Employee's death, divorce or legal separation, or entitlement to Medicare benefits; or the ineligibility of the Employee's Dependent child;

provided the Eligible Person or Eligible Dependent elects Continuation Coverage within sixty (60) days after the later to occur of (1) the date the Qualifying Event would cause him or her to lose coverage, or (2) the date the Employer notifies the Eligible Person or Eligible Dependent of his or her Continuation Coverage rights; and provided the required contributions are submitted.

2. COBRA participants are required to pay the entire cost for their coverage, including administration costs if applicable.

PENDING APPROVAL

- a. The day on which expiration of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month Continuation Coverage period, whichever is applicable, occurs;
 - b. The first day that begins more than thirty (30) days after the date of the Social Security Administration's final determination that the person is no longer disabled (when coverage has been extended from eighteen (18) months to twenty-nine (29) months due to disability);
 - c. The date on which the Employer ceases to provide any group dental plan to any Employee;
 - d. The date on which coverage ceases because of a person's failure to make timely payment to the Employer of any dues required for the Continuation Coverage;
 - e. The date on which the person becomes covered under any other group dental plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to that person;
 - f. The date on which the person becomes entitled to benefits under Medicare;
 - g. On the last day for which the last payment has been made if the Plan Administrator fails to make payment to the Claims Administrator;
 - h. On the date on which this Plan is terminated or canceled.
3. Termination of the Plan automatically terminates all Covered Persons' coverage at the same time and date.

PENDING APPROVAL

SECTION 4 - COVERED DENTAL SERVICES

Subject to the Exclusions, Limitations, and conditions of the Plan, a Covered Person is entitled to Benefits for the following Covered Services in the amounts specified in the Schedule of Benefits.

A. CLASS I SERVICES

1. **Diagnostic Services:** Procedures performed by Dentists in evaluating existing conditions to determine the recommended dental treatment. By way of description, such services include: Oral evaluations (examinations), emergency palliative treatment, and x-rays.
2. **Preventive Services:** Dental procedures or techniques usually performed by Dentists to prevent the occurrence of dental disease. By way of description, such services include: Routine prophylaxis (cleaning); and topical application of fluoride, limited sealants, and space maintainers for eligible dependent children.

B. CLASS II SERVICES

1. **Restorative Services:** The services usually performed by Dentists in the treatment of carious lesions (decay/cavity). By way of description, such services include: Amalgam and composite restorations (fillings); and stainless steel restorations (crowns) for eligible dependent children.
2. **Oral Surgery Services:** Procedures for extractions and other oral surgery procedures.
3. **Endodontic Services:** Procedures usually performed by Dentists for the treatment of nonvital teeth. By way of description, such services include: Pulpal therapy and root canal treatment.
4. **Periodontic Services:** Procedures usually performed by Dentists for the treatment of disease of the gums and bone supporting the teeth, including but not limited to periodontal maintenance procedures following active therapy.
5. **Prosthodontic Services:** Re-cementing fixed partial dentures (bridges) and adjustment or repair to dentures.

C. CLASS III SERVICES

1. **Major Services:** Provides porcelain or cast restorations (other than stainless steel) for the treatment of carious lesions (decay/cavity) when teeth cannot be restored with another filling material. *Note: A crown or cast restoration is optional treatment unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration.*
2. **Prosthodontic Services:** Procedures for construction of fixed partial dentures (bridges), removable partial dentures, and complete dentures.

PENDING APPROVAL

SECTION 5 - LIMITATIONS AND EXCLUSIONS

- A. **LIMITATIONS:** The Benefits to be provided to Eligible Persons and Eligible Dependents under this Plan shall be limited as follows:
1. For purposes of this Plan, any procedure frequency limitation is measured in a period of continuous calendar-year months (a consecutive month period), which begins on the date on which the procedure was last rendered.
 2. Prophylaxis is a Benefit twice in a twelve (12) consecutive month period. *Note: Cleanings/prophylaxis of any type, including periodontal maintenance, are limited to any combination of two in a twelve (12) consecutive month period.*
 3. Oral evaluation is a Benefit twice in a twelve (12) consecutive month period.
 4. Limited (emergency) oral evaluation is a Benefit twice in a twelve (12) consecutive month period. *Note: Benefits for limited (emergency) oral evaluation may be disallowed if other services are provided on the same day.*
 5. Consultation (D9310) is a Benefit once in a twelve (12) consecutive month period.
 6. Bitewing x-rays are a Benefit once in a twelve (12) consecutive month period. *Note: Benefits may be limited if multiple same-day x-rays are provided on the same day by the same dentist/dental office.*
 7. Full-mouth x-rays, a panoramic film, multiple same-day x-rays, or vertical bitewings-7 to 8 films is a Benefit once in a sixty (60) consecutive month period unless necessary for the diagnosis and treatment of a specific disease or injury.
 8. Topical application of fluoride solutions is a Benefit for patients through age eighteen (18), and once in a twelve (12) consecutive month period.
 9. A space maintainer is a Benefit for missing primary posterior teeth for children through age fifteen (15), and not for orthodontic purposes.
 10. Sealants are a Benefit for persons through age fifteen (15), limited to permanent first and second molar teeth free of caries (decay/cavity) and restorations on the occlusal surfaces. Sealants are a Benefit once per tooth in a sixty (60) consecutive month period.
 11. Stainless steel crowns are a Benefit for persons through age eleven (11), limited to once per tooth in an eighty-four (84) consecutive month period.
 12. Posterior composite restorations are not a covered benefit. A corresponding amalgam restoration allowance may be made, and the patient is responsible for any difference in cost.
 13. General anesthesia/IV sedation is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the fee for

PENDING APPROVAL

treatment, patient will be responsible for any charges in excess of this plan's payment. For example: if a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment based on such procedure will be made toward a more elaborate or precision appliance the dentist and patient may choose to use, and patient is responsible for the balance of the cost; a fixed partial denture (bridge) will be allowed only when a removable partial denture will not suffice; if a crown or cast restoration is not allowed, an alternate benefit allowance for an amalgam or composite restoration may be made and any fee charged in excess of the allowance is chargeable to the patient; etc. Implants are not a benefit, but if implantology techniques are utilized, the plan will make an alternate benefit allowance toward the cost of the appliance constructed in association therewith or over the implant(s), and the patient may be responsible for any fee charged in excess of the alternate allowance.

22. The plan's obligation to provide Benefits for Covered Dental Services terminates on the date on which the patient becomes ineligible for Benefits under the plan.
23. Care terminated due to death will be paid in full, to the limit of the Plan's liability, for services completed or in progress.
24. When services in progress are interrupted and completed later by another Dentist, DDPOK will review the claim to determine the payment to each Dentist.
25. Processing policies, if applied, may limit benefits and can be found on each Explanation of Benefits.
26. Charges for any covered dental service or supplies which are included as covered medical expenses under the plan of Major Medical or Comprehensive Medical Expense Benefits Plan must first be submitted for payment to the medical carrier. This Plan may benefit as the secondary carrier.

B. EXCLUSIONS: The following shall be excluded from the benefits and services to be provided to Eligible Persons and Eligible Dependents under the Plan.

1. Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability laws.
2. Benefits or services which are provided free of charge by any federal or state government agency, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.
3. Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.
4. Benefits for services or appliances started prior to the date the patient became eligible under the Plan may be excluded.
5. Benefits for services when a claim is received for payment more than twelve (12) months after the date of service.

SECTION 6 - COORDINATION OF BENEFITS (COB)

If an Eligible Person or Eligible Dependent is covered for Dental Services or Benefits by another third party provider's contract, arrangement, or insurance carrier, the Plan's liability for payment will be determined as follows:

- A. A plan with no rules for coordination with other Benefits will be deemed to pay its Benefits before a plan that contains such rules.
- B. A plan that covers a person other than as a Dependent will be deemed to pay its Benefits before a plan that covers the person as a Dependent.
- C. A plan that covers the person as a Dependent of a person whose birthday comes first in a Calendar Year will be primary to the Plan that covers the person as a Dependent of a person whose birthday comes later in that Calendar Year. If a plan does not have this provision regarding birthdays, the rule set forth in that plan will determine the order of Benefits. If the person for whom claim is made is a Dependent child and the parents are separated or divorced:
 - 1. If there is a court decree which would establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the Benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the Benefits of any other plan which covers the child as a Dependent child.
 - 2. If there is not a court decree which would establish financial responsibility for the medical, dental, or other health care expenses with respect to the child:
 - a. If the custodial parent has not remarried, the Benefits of a plan which covers the child as a Dependent of the custodial parent will be determined before the Benefits of a plan which covers the child as a Dependent of the noncustodial parent.
 - b. If the custodial parent has remarried, the Benefits of a plan that covers the child as a Dependent of the custodial parent shall be determined before the Benefits of a plan which covers that child as a Dependent of the stepparent or the noncustodial parent. The Benefits of a plan which covers that child as a Dependent of the stepparent will be determined before the Benefits of a plan which covers that child as a Dependent of the noncustodial parent.
- D. If A, B, and/or C above do not establish an order of payment, the Plan under which the person has been covered for the longest period of time will be deemed to pay its Benefits first, except that:
 - 1. The Benefits of a plan that covers the person as a laid-off or retired Employee, or as a Dependent of such person, pays after the contract which covers such person as other than a laid-off or retired Employee, or a Dependent of such person.
 - 2. If either plan does not have a provision regarding laid-off or retired Employees and, as a result, each plan determined its Benefits after the other, the paragraph immediately preceding will not apply.

D. PREDETERMINATION OF BENEFITS

Predetermination of Benefits should be requested if the cost of the recommended treatment Plan exceeds \$150. DDPOK will issue an estimate of benefits regarding the Attending Dentist Statement (claim form) when satisfied that the patient is eligible for Benefits. The Predetermination will be for a maximum period of 365 days from the date of Predetermination by DDPOK (180 days for Periodontal procedures), but not longer than the period this Plan is in effect.

E. PAYMENT OF BENEFITS

1. DDPOK is authorized by the Plan and the Covered Person to make payments directly to Dentists furnishing services for which Benefits are provided. However, DDPOK reserves the right to make payments directly to the Covered Person.
2. Once Covered Services are rendered by a Dentist, DDPOK will not honor Covered Persons' requests not to pay the claims submitted by the Dentist. DDPOK will have no liability to any person because of its rejection of the request.
3. Anytime a claim is filed, by the Eligible Person or a dentist, the Eligible Person will receive a form called an Explanation of Benefits (EOB) from DDPOK within a reasonable time, but no later than 30 days after receipt of a claim. DDPOK may extend this time period one time up to 15 days, prior to the expiration of the 30-day period. If DDPOK requires additional information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Eligible Person will be given 45 days from receipt of the notice within which to provide the necessary information.
4. DDPOK will make payment of that portion of the fee for which the Plan is liable in accordance with this Appendix A and such uniform policies and procedures as are deemed proper by the Board of Directors of DDPOK and the Plan Administrator. Payment for Covered Services shall be as follows:
 - a. If a Delta Dental PPO Participating Dentist provides covered treatment, the Plan will pay its Benefits to the Dentist at the applicable Percentage of the Allowable Charge specified in the Schedule of Benefits based on the Dentist's submitted fee or the maximum allowable amount for Delta Dental PPO Participating Dentists, whichever is less. Payment of Benefits will be subject to any applicable Covered Person's Copayment, Deductible, and/or Maximum Benefit Payment. The Plan's payment, together with the Covered Person's portion of the fee required, shall discharge the claim of a Delta Dental PPO Participating Dentist.
 - b. If a Delta Dental Premier Participating Dentist provides covered treatment, the Plan will pay its Benefits to the Dentist at the applicable Percentage of the Allowable Charge specified in the Schedule of Benefits based on the Dentist's submitted fee or the maximum allowable amount for Delta Dental Premier Participating Dentists, whichever is less. Payment of Benefits will be subject to any applicable Covered Person's Copayment, Deductible, and/or Maximum Benefit Payment. The Plan's payment, together with the Covered Person's portion of the fee required, shall discharge the claim of a Delta Dental Premier Participating Dentist.

F. NOTICE

Any notice required or permitted to be given hereunder shall be given in writing and personally delivered or in writing and deposited in the United States mail with postage prepaid. Notice given to the Employer will be sent to the Employer's address stated in the records of the Plan. Notice given to DDPOK will be sent to DDPOK's address as stated in the records of the Plan. Notice given to the Covered Person will be sent to the Covered Person's address as it appears in the records of the Plan or in care of the Employer. Notice given to a Dentist will be sent to the Dentist's address stated in the records of DDPOK. Such notice shall be deemed to have been duly given when so personally delivered or three (3) days after having been placed in the United States mail, with postage prepaid and return receipt requested. The Employer, DDPOK, a Covered Person, or a Dentist may, by written notice, indicate a new address by giving notice.

G. RELEASE OF INFORMATION

In consideration of waiving physical examination of an Eligible Person or Eligible Dependent and as a condition precedent to the approval of claims hereunder, DDPOK shall be entitled to receive from any attending or examining Dentist, or from any facility in which a Dentist's care is rendered, such information and records relating to attendance to or examination of any Covered Person required in the administration of such claim, provided, however, that DDPOK shall, in every case, preserve the confidentiality of such information except as is necessary for the proper administration of the Plan.

H. LIMITATION OF ACTION

No action at suit of law or equity shall be commenced upon or under this Plan until thirty (30) days after notice of claim has been given to DDPOK, nor shall action be brought at all later than three (3) years after such claim has arisen.

I. POWERS OF PLAN ADMINISTRATOR

1. If any section, word, term, or phrase in the Plan is deemed to be ambiguous, it shall be the responsibility of the Plan Administrator to define same.
2. If any provision in the Plan is, on its effective date, in conflict with the statutes of the state in which the Covered Person resides, it is hereby agreed by the Plan Administrator that the intent is for the provision to be amended to the minimum requirement of such statute.
3. Plan Administrator assumes the legal role as the Plan's fiduciary. For purposes of the Plan, DDPOK shall have the right to determine the amount of Benefits, if any, payable from the Plan's funds on behalf of a Covered Person. Such determination shall be based on provisions of the Plan. Notwithstanding any claims decision by DDPOK, the Plan Administrator shall have the absolute right to review any and all claims decisions (including both payment and denial of claims) and overrule any and all such decisions, on a case-by-case basis, in Plan Administrator's sole discretion as the Plan fiduciary.