

## **CHARLES COUNTY GOVERNMENT**

GROUP #7144

DELTA DENTAL PPO DENTAL SERVICE CONTRACT  
FOR EXPERIENCE RATED GROUPS  
("Contract")

effective as of

July 1, 2007

by and between

CHARLES COUNTY GOVERNMENT

(hereafter called Company)

and

DELTA DENTAL OF PENNSYLVANIA

One Delta Drive  
Mechanicsburg, PA 17055

a Pennsylvania non-profit corporation (hereafter called "Delta Dental")

WITNESSETH THAT THE PARTIES AGREE AS FOLLOWS:

This Dental Service Contract affords national access to all Delta Dental Plans to all Enrollees.

DELTA DENTAL OF PENNSYLVANIA  
DELTA DENTAL PPO DENTAL SERVICE CONTRACT  
FOR EXPERIENCE RATED GROUPS

TABLE OF CONTENTS

|                                                              | <u>PAGE</u> |
|--------------------------------------------------------------|-------------|
| ARTICLE I      Definitions                                   | 1           |
| ARTICLE II     Enrollment                                    | 6           |
| ARTICLE III    Entitlement to Services                       | 7           |
| ARTICLE IV    Administration of Claims for Services          | 7           |
| ARTICLE V     Coordination of Benefits                       | 9           |
| ARTICLE VI    Payment for Covered Services                   | 11          |
| ARTICLE VII   Exclusions and Limitations                     | 12          |
| ARTICLE VIII   General Provisions                            | 12          |
| ARTICLE IX    Reports and Records and Inspection Thereof     | 15          |
| ARTICLE X     Contract Renewal, Modification and Termination | 16          |
| ARTICLE XI    Extent of Entire Contract                      | 18          |
| ARTICLE XII   Cancellation of Existing Contracts             | 18          |
| Schedule I                                                   |             |
| Schedule II                                                  |             |
| Appendix A                                                   |             |
| Addendum                                                     |             |

## ARTICLE I. DEFINITIONS

- A. Allowed Amount shall mean either the Maximum Plan Allowance, the equivalent amount as stated in the National Provider File for Participating Dentists of other Delta Dental Plans on which program deductibles, maximums and copayments are based, or the charged fee whichever is less.
- B. Attending Dentist Statement shall mean the written report of a series of procedures recommended for the Treatment of a specific dental disease, defect or injury, prepared for an Enrollee by a Dentist as a result of an examination made by such Dentist.
- C. Business Associate Addendum is a written contract between Company and Delta Dental, as a business associate of Company, that provides satisfactory assurances to Company that the release, disclosure, and/or use of Protected Health Information (PHI), shall be protected and conducted with appropriate safeguards in compliance with HIPAA.
- D. Calendar Year means the twelve-month period commencing at 12:01 a.m. January 1<sup>st</sup> of every year and terminating at 12:00 midnight on December 31<sup>st</sup>.
- E. Continuation Coverage shall mean identical coverage for the periods indicated for Employees and eligible Dependents at their own expense as follows:
  - 1. Eighteen (18) months for Employees and their Dependents losing coverage through (a) termination (other than for gross misconduct), or (b) reduction in work hours; extended up to twenty-nine (29) months, if disabled, as that word is defined in Titles II and XVI of the Social Security Act.
  - 2. Thirty-six (36) months for (a) dependent children of surviving spouses; (b) dependent children of divorced or legally separated spouses; (c) Medicare ineligible dependent children of current Employees entitled to Medicare or of former Employees on Continuation Coverage entitled to Medicare; (d) dependent children losing coverage under the provisions of Article I, Paragraph L, Subparagraph 2 and Subparagraph 3.
  - 3. Until the date of re-marriage for persons who qualified as a covered dependent by reason of being the spouse of a Primary Enrollee.
  - 4. Continuation Coverage shall terminate on the happening of one of the following events, whichever is sooner:
    - (a) The applicable period for Continuation Coverage ends;
    - (b) Thirty (30) days after the date of final determination that a person on extended coverage is no longer disabled;
    - (c) Enrollee subsequently becomes covered under another group dental plan having equivalent coverage which does not have exclusions or limitations for pre-existing conditions or becomes entitled to dental coverage from Medicare;

- (d) Premium for Continuation Coverage is not paid on time.
5. Eligibility for Continuation Coverage shall be determined by Company. Notification of election of Continuation Coverage, changes in Continuation Coverage and termination of Continuation Coverage shall be in accordance with the procedure described in Article II, Paragraph D.
6. The provisions of Article IV, Paragraph H concerning Limitation on Liability for Claims on Termination of the Contract or of Enrollees who have lost Eligibility, are expressly applicable to loss of eligibility on account of termination of Continuation Coverage.
- F. Contract Term shall mean a period commencing at 12:01 a.m. on July 1, 2007, and terminating at 12:00 midnight on June 30, 2008.
- G. Contract Year shall mean the twelve-month period commencing on the Effective Date and each yearly period thereafter.
- H. Delta Dental Participating Plan Agreement shall mean the agreement with the Delta Dental Plans Association providing national access to Delta Dental's multi-state dental programs involving single-site processing with payment to local Participating Dentists at the local state's Allowed Amount.
- I. Delta Dental Plans Association shall mean the national organization of various Delta Dental Plans.
- J. Delta Dental PPO shall mean a dental care program for Enrollees under which all fees paid or otherwise discharged by Delta Dental for Services shall be the PPO Allowed Amount, subject to any applicable co-payments, deductibles and maximums.
- K. Delta Dental Premier<sup>®</sup> shall mean a dental care program for Enrollees under which all fees paid or otherwise discharged by Delta Dental for Services shall be the Allowed Amount, subject to any applicable co-payments, deductibles and maximums.
- L. Delta Dental Plans shall mean members of the Delta Dental Plans Association.
- M. Dental Affairs Committee shall mean a duly appointed committee of the Board of Directors of Delta Dental.
- N. Dental Consultants shall mean the Dentist employed or retained by Delta Dental to review claims assigned to them.
- O. Dentist shall mean any doctor of dental surgery (DDS), doctor of dental medicine (DMD), or other established dental degree, duly licensed by the applicable government authority to practice dentistry.

P. Dependents shall be defined within the following by Company:

1. The Primary Enrollee's spouse.
2. The Primary Enrollee's unmarried children and/or dependent grandchildren until the end of the calendar year of their 19<sup>th</sup> birthday. Such children include (a) a blood descendant of the first degree, (b) a legally adopted child (including a prospective adoptive child of the adopting parents and/or grandparents from the earlier of the date of the judicial decree of the adoption or the assumption of custody pending adoption), (c) a child for whom the Primary Enrollee has legal guardianship or temporary guardianship of more than twelve (12) months duration and for a shorter period if the guardianship is of a dependent minor and granted by testamentary appointment, (d) a stepchild of the Primary Enrollee, or (e) a child or grandchild who is the subject of a Court Order of support directed to a Primary Enrollee without regard to the amount of support contributed by the Primary Enrollee, the amount of time the child spends in the home of the Primary Enrollee or the custodial arrangement for the child. Documentation of the above must be furnished as required by Delta Dental.
3. Unmarried children and/or unmarried dependent grandchildren of a Primary Enrollee who are full-time students in a bona fide educational institution until the end of the calendar year of their 25<sup>th</sup> birthday. Proof of continuing attendance therein must be furnished as required by Delta Dental.
4. All unmarried children and/or unmarried dependent grandchildren of a Primary Enrollee covered by the Contract prior to attainment of age 19 including those who are incapable of self-support by reason of mental or physical incapacity and/or those who became incapable prior to age 19 and who are chiefly dependent upon the Primary Enrollee for support and maintenance. Eligibility of these dependent children and/or grandchildren shall not terminate while the Contract remains in force and the dependent child or grandchild remains in such condition. The dependent child or grandchild is not required to reside with a parent or legal guardian who is a Primary Enrollee. Proof of physical or mental disability must be furnished as required by Delta Dental.
5. Newborn children and/or dependent grandchildren of any Enrollee from the moment of birth, from the date of adoption or from the date of appointment for a minor for whom guardianship has been granted by court or testamentary appointment for thirty-one (31) days after birth. Proof of birth or adoption must be furnished as required by Delta Dental, the cost of which shall be paid by Delta Dental.

Q. Effective Date of this Contract shall be 12:01 a.m. on July 1, 2007.

R. Employee shall mean an Employee of the Company who meets the eligibility requirements, accepted by Delta Dental, for enrollment under the Contract, and who is so specified for enrollment.

- S. Enrollee shall mean, collectively, the Primary Enrollee and all enrolled Dependents, persons eligible for Continuation Coverage, or any of such persons, as designated by the Company.
- T. ERISA shall mean the Employee Retirement Income Security Act of 1974.
- U. Family shall mean the Primary Enrollee and all enrolled Dependents of the Primary Enrollee.
- V. Health Insurance Portability and Accountability Act of 1996, ("HIPAA") shall mean the statute located at 42 U.S.C. §1396 et seq., and the regulations codified at 45 C.F.R. Parts 160 and 164.
- W. Loss of Eligibility Date Eligibility of Employees, their spouses and Dependents shall terminate on the last day of the month in which termination of employment occurs or until notice of termination has been received by Delta Dental, whichever last occurs.
- X. Maximum Plan Allowance shall mean the amount payable for Services of Participating and Non-Participating Dentists, calculated by Delta Dental, for use in payment by it and by its Enrollees from claim charges submitted, on a regional basis, for a given Service by Dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.
- Y. National Provider File shall mean the file maintained by Delta Dental Plans Association listing Maximum Allowable Amounts or equivalents per procedure, by product and network status used by Delta Dental Plans.
- Z. Non-Participating Dentist shall mean a Dentist who has not entered into a Participating Dentist Agreement with Delta Dental or another Delta Dental Plan.
- AA. Participating Dentist shall mean a Dentist, who has entered into a Participating Dentist Agreement which is currently in effect with Delta Dental or another Delta Dental Plan. A Participating Dentist agrees to abide by the terms and conditions of his/her Agreement and published Bylaws which provide that a Participating Dentist shall be subject to Dental Service Contracts under which an Enrollee is covered by Delta Dental insofar as they regulate the Services to be provided to Enrollees, the basis of payment therefore, and any other matter pertaining to the obligation of Delta Dental to Enrollees. Delta Dental shall periodically provide a current listing of Participating Dentists to Company.
- BB. Participating Dentist Agreement shall mean the contract between Delta Dental and the Participating Dentist who agrees to accept Delta Dental's Allowed Amount and certain other conditions when treating an Enrollee.
- CC. PPO Allowed Amount shall mean either the PPO Maximum Plan Allowance for Participating Dentists, or the charged fee, whichever is less.

- DD. PPO Dentist shall mean a Participating Dentist as defined in Article I, Paragraph AA, who agrees to accept payment, as described in Article VI, Paragraph A, as full payment for Services, provided under this Contract to Enrollees.
- EE. PPO Maximum Plan Allowance shall mean an amount, determined by Delta Dental, usually less than its Maximum Plan Allowance for Delta Dental Premier programs, from claim charges submitted on a regional basis for a given Service by Dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.
- FF. Premium shall mean the Premium or pre-fund payment described in Schedule I, which Schedule is incorporated herein and made a part hereof by reference, as well as the Premium paid by, or on behalf of, an Enrollee for Continuation Coverage. Premiums for Continuation Coverage shall be payable to Company, and by Company to Delta Dental, in amounts allowable by law and based on the amounts provided in Schedule I.
- GG. Pre-Treatment Estimate shall mean the pre-treatment review by Delta Dental of an Attending Dentist Statement to determine the eligibility of the Enrollee and the benefits available for proposed procedures in accordance with Article IV, Paragraph C.
- HH. Primary Enrollee shall mean an Employee who is enrolled hereunder.
- II. Prospective Rating Method shall mean the rating method where Delta Dental is at risk for claims cost versus Premium.
- JJ. Protected Health Information, ("PHI") shall mean information related to an Enrollee's health status or treatment received, that is individually identifiable by reference to the Enrollee.
- KK. Records shall mean the data collected by Delta Dental regarding claims administration.
- LL. Retention Rating Method shall mean the rating method where Delta Dental is at risk for losses, but surpluses are refunded to the purchaser.
- MM. Services shall mean the Treatments set forth in Schedule II and any applicable Riders to Schedule II, which Schedule and Riders are incorporated herein and made a part hereof by reference, the provisions, conditions, limitations and exclusions contained in Schedule II, performed by a Dentist or under his supervision and direction and when necessary, customary and reasonable, as determined by Delta Dental, using standards of generally accepted dental practice.
- NN. Single Procedure shall mean a dental procedure to which a separate procedure number is assigned by Delta Dental.
- OO. Treatment shall mean a caring for or dealing with an oral condition.

## ARTICLE II. ENROLLMENT

- A. Enrollment of Enrollees. Company shall enroll Enrollees prior to the onset of the Contract and update such information monthly or more frequently if selected by Company thereafter during the Contract Term. This enrollment or update shall be accomplished by Company supplying to Delta Dental a listing of all Primary Enrollees, on enrollment cards furnished by Delta Dental, by entry on a returned billing statement, by magnetic tape, or in such other format selected by Company and approved by Delta Dental. Such listing or format shall include the full names and the Enrollee ID numbers of the Primary Enrollees and whether they are single or have Dependents if eligibility is extended to them under Schedule I, which Schedule is incorporated herein and made a part hereof by reference.

However, if a parent eligible for family members' coverage is required by court or administrative order to furnish coverage for a dependent child, that child shall be entitled to coverage regardless of enrollment period restrictions. If the parent eligible for family member's coverage does not elect coverage for the dependent child, the non-insuring parent, child support enforcement agency, or Department of Health and Mental Hygiene shall be allowed to apply for enrollment on behalf of the child regardless of enrollment period restrictions. Such coverage shall remain in effect unless written evidence is provided to Delta Dental that the order is no longer in effect and the child has been or will be enrolled under other dental insurance coverage that will take effect on or before the termination of this contract, the Company has eliminated family members' coverage for all employees, or the parent is no longer eligible. The parent may then elect Continuation Coverage pursuant to Article I, Paragraph E for that child.

- B. Eligibility. Persons eligible for enrollment as Enrollees shall be those persons described in Schedule I. Eligible new Enrollees may be added periodically in accordance with the provisions of Paragraph A of Article II.
- C. Change in Eligibility Status. If Dependents, as designated in Schedule I, are eligible for enrollment and if an Enrollee is initially enrolled as a single person and the enrollment status changes to that of Family during the term of this Contract, such change must be indicated to Delta Dental in writing on enrollment cards furnished by Delta Dental, by entry on a returned billing statement, by magnetic tape or in such other format selected by Company and approved by Delta Dental, within thirty (30) days following such change. If a person is initially enrolled at a family rate and his/her status changes to that of single during the term of this Contract, such change must be reported to Delta Dental in writing as described within thirty (30) days following such change.
- D. Loss of Eligibility. If an Enrollee who has been previously certified by Company as eligible loses his/her eligibility, Company shall immediately notify Delta Dental in writing by entry on returned billing statement or magnetic tape or on enrollment cards furnished by Delta Dental or in such other format selected by Company and approved by Delta Dental. If the parent eligible for family member's coverage who is under court or administrative order to provide coverage for a dependent child does not elect coverage for the dependent child, the non-insuring parent, child support enforcement agency, or Department of Health and Mental Hygiene shall be allowed to apply for enrollment on

behalf of the child regardless of enrollment period restrictions. Such coverage shall remain in effect unless written evidence is provided to Delta Dental that the order is no longer in effect and the child has been or will be enrolled under other dental insurance coverage that will take effect on or before the termination of this contract, the Company has eliminated family members' coverage for all employees, or the parent is no longer eligible. The parent may then elect Continuation Coverage pursuant to Article I, Paragraph E for that child.

- E. Eligibility of Newborn Children or Grandchildren. In order for the coverage of newborn children or grandchildren, newly adopted children or grandchildren from the earlier of the date of the judicial decree of the adoption or the assumption of custody pending adoption or of dependent minors under guardianship from the date of the court or testamentary appointment to continue beyond the thirty-one (31) day period, Delta Dental must be notified of the birth of the newborn child, the earlier of the date of adoption or the assumption of custody pending adoption or the date of the court or testamentary appointment in writing on enrollment cards furnished by Delta Dental, by entry on a returned billing statement or magnetic tape or in such other format selected by Company and approved by Delta Dental, if payment of a specific premium or subscription fee is required for continuation of coverage, and payment of the required Premium must be furnished to Delta Dental within thirty-one (31) days after birth, the earlier of the date of adoption or the assumption of custody pending adoption or the date of the court or testamentary appointment.

### ARTICLE III. ENTITLEMENT TO SERVICES

- A. Right to Services. In consideration of the payment of Premiums by the Company, as provided in Schedule I, each Enrollee is entitled to Services under this Contract.
- B. Right to Choose Dentist. An Enrollee may choose either a Participating Dentist or a Non-Participating Dentist to provide Services.
- C. Right to Referral. An Enrollee shall have a right to referral by the attending dentist to either a Participating or a Non-Participating Dentist who is a specialist in any field of dentistry and is so considered by Delta Dental subject to the payment limitations of Article VI, Paragraph D.

### ARTICLE IV. ADMINISTRATION OF CLAIMS FOR SERVICES

- A. Approval of Claims. Delta Dental shall administer all claims in accordance with the terms of this Contract. Payment shall be made only on approved claims.
- B. Notification of Dentist. The Enrollee shall notify the Dentist that he/she is an Enrollee under this Contract prior to Treatment and provide the Dentist with his/her Enrollee ID number and group number.

- C. Pre-Treatment Estimate of Benefits. If the charges for Services to be provided to an Enrollee exceed an amount which Delta Dental shall set and adjust periodically, an Enrollee may request the attending Dentist to submit his/her Attending Dentist Statement to Delta Dental for Pre-Treatment Estimate of benefits before performing his/her procedures. Delta Dental shall notify the Dentist whether the procedures are within the Services covered by the Contract. The notification shall also state the amount which will be paid providing the Enrollee is eligible on the date when each respective procedure is commenced, the procedures are completed within a sixty (60) day period following the date of the Pre-Treatment Estimate notice and the claim is submitted within the period set forth in Article IV, Paragraph I, the benefits continue to be within applicable benefit maximums and frequency of procedure limitations. Subject to the continuing eligibility of the Enrollee, applicable benefit maximums not being exhausted and continuing inapplicability of frequency or procedure limitations, Delta Dental will grant extensions of a benefit Pre-Treatment Estimate period upon request from the Dentist or the Enrollee.
- D. Supporting Material for Claims. Delta Dental shall be entitled to receive from any Dentist such information and records or copies of records relating to examinations, diagnosis, and Treatment performed for any Enrollee as may be required to determine eligibility of the Enrollee, Treatment coverage and fees payable under this Contract. All records of patients shall be confidential and nothing therein shall be made public except as provided in Article IX, Paragraph B.
- E. Denial of Claim. Delta Dental has installed an extensive internal grievance procedure sensitive to the rights of Enrollees. See Appendix A. In no event may an Enrollee bring an action in law or equity before the expiration of sixty (60) days after a claim is filed or more than three (3) years from the date that written proof of loss is required to be furnished.
- F. Utilization Review for Quality Control. Delta Dental shall make periodic investigations of the quality of Services being provided under this Contract, and for such purposes Delta Dental may enlist the aid of local dental consultants. Company shall be provided with results of such investigation, subject to the provisions of Article IX, Paragraph B.
- G. Limitation on Initial Assumption of Liability for Claims. Unless and until the first Premium payment is received by Delta Dental from the Company, pursuant to Schedule I, and unless and until the first enrollment lists and/or enrollment cards are received by Delta Dental from the Company, pursuant to Article II, at its principal office, Delta Dental shall have no obligation to process any claim under this Contract for Enrollees.
- H. Limitation on Liability for Claims on Termination of the Contract or of Enrollees who have Lost Eligibility. In the event of termination of this Contract or the loss of eligibility of an Enrollee, Delta Dental shall extend benefits beyond the termination date of the Contract or the Loss of Eligibility Date and pay for Services beyond such dates for at least ninety (90) days or until such Services are complete for any Treatment commenced while the Contract was in effect or the Enrollee was eligible.

In the case of Orthodontic Procedures, notwithstanding any other limitation on Orthodontic Benefits, the extension of benefits exception in the previous paragraph is and shall be interpreted to mean continuation until half of the orthodontic Treatment is complete if the orthodontist has received the first 50% of the Delta Dental benefit; or for ninety (90) days or until the end of the quarter in progress, whichever is longer, if the orthodontist has agreed to or is receiving quarterly payments when coverage terminates.

Any claims paid by Delta Dental on behalf of an ineligible person or after Contract termination, except for the extension of benefits in the previous two paragraphs, shall be the obligation of the Company and shall be charged to Company as additional Premiums payable in accordance with Schedule I. Notwithstanding the other provisions of this Paragraph of this Article, if Delta Dental has received notice of loss of eligibility pursuant to Article II, Paragraph D or termination of the Contract pursuant to Article X, Paragraphs A, C, and K, and pays a claim after the Loss of Eligibility Date or termination date which would otherwise be the obligation of the Company under this Paragraph of this Article, then such claims shall be the obligation of Delta Dental.

- I. Time Limitations on Payment of Claims. Delta Dental shall not be obligated to pay claims submitted more than twelve (12) months after the date of providing the Service. If a claim is denied due to a Participating Dentist's failure to make timely submission, the Enrollee shall not be liable to such Dentist for the amount which would have been payable by Delta Dental provided the Enrollee notified the Dentist of his/her eligibility at the time of Treatment. Failure to furnish proof of loss by the Enrollee within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

#### ARTICLE V. COORDINATION OF BENEFITS

- A. In the event that any Enrollee hereunder is entitled to benefit under any benefit program other than that described in this Contract, the following Coordination of Benefits provision shall determine the sequence and the extent of payment of the expense for benefits provided under this Contract. Allowable expenses shall mean like items of expense to those which are benefits under this Contract. Such other benefit program may include any Company-sponsored program including any group Blue Cross/Blue Shield plan, Delta Dental program or other group prepayment program, group coverage through Health Maintenance Organization and other group practice and individual practice plans, or any Company-sponsored insurance program in which the Enrollee is enrolled. Blanket student accident insurance or Medicaid shall not be coordinated. Health programs of any kind shall not be coordinated when the Employee or other individual pays the entire cost thereof or when the program provides any periodic payment or any other payment by the program to Enrollees which is not related to the value of the Service provided to each Enrollee on account of illness or injury.

- B. When a claimant is covered under another benefit program to which this Article applies, the following rules will be followed to establish the order of determining liability of this or any other programs:
1. The program covering the Enrollee as an Employee will determine its benefits before the program which covers the Enrollee as a Dependent.
  2. The program covering the Enrollee as a Dependent of an Employee whose birthday falls earlier in the **Calendar Year** will determine its benefits before the program covering the Enrollee as a Dependent of an Employee whose birthday falls later in the Calendar Year. If both Employees have the same birthday, the program covering the Employee for the **longest period** will determine its benefits before the program covering the Employee for the shorter period.
  3. The program covering the Enrollee **having custody** of the Dependent will determine its benefits first; then the program of the spouse of the parent with custody of the Dependent; and finally, the program of the parent not having custody of the Dependent. However, if the specific terms of a Court Order state that one of the parents is responsible for the health care expenses of the Dependent, the benefits of that program are considered first. The prior sentence shall not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the Court Order.
  4. The program covering the Enrollee as an Employee or as a Dependent of an Employee will determine its benefits before one which covers the Enrollee as a laid-off or retired Employee or as the Dependent of such person. If the other plan does not have a rule concerning laid-off or retired Employees, and as a result each plan determines its benefits after the other, then the provisions of this Subparagraph shall not apply.
  5. If the other program does not contain provisions establishing the same order of determining liability for benefits or is one which is "excess" or always "secondary", Delta Dental shall determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, for purposes of Paragraphs C and D of this Article, Delta Dental shall be considered as not the first to determine its benefits.
  6. In situations not described in Subparagraphs 1, 2, 3, 4, and 5 of this Paragraph, the program under which the Enrollee has been enrolled for the longest period of time will determine its benefits first.
- C. When Delta Dental is the first to determine its benefits, benefits hereunder will be paid without regard to coverage under any other program.

- D. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable hereunder, Delta Dental shall pay the amount it would have paid had it been the first to pay benefits, or the amount of such remaining expenses, whichever is less. In no event, shall Delta Dental pay more than the remaining dentist charges after the first Plan pays which would be allowable for Maximum Plan Allowance calculations or the Allowed Amount whichever is less.
- E. For the purpose of determining the applicability and implementing the terms of this provision of this coordination of benefits provision of this program or any provision of similar purpose of any other program, Delta Dental may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person demand or make payment which it deems to be necessary for such purposes, and in so acting, Delta Dental shall be free from any liability that might arise in relation to such action. Any person claiming benefits under this program shall furnish to Delta Dental such information as may be necessary to implement this provision. Notwithstanding the foregoing, to the extent that a HIPAA Business Associate Addendum between Delta Dental and Company is in effect, and applicable to the disclosure, any disclosure of information by Delta Dental shall be in accordance with that Business Associate Addendum.

#### ARTICLE VI. PAYMENT FOR COVERED SERVICE

- A. Fees of Participating Dentists. All fees paid or otherwise discharged by Delta Dental to Participating Dentists or Participating Dentists of other Delta Dental Plans for Services provided to Enrollees under a Delta Dental PPO program, shall be the PPO Allowed Amount, except as constrained by Article VI, Paragraph C.
1. A Participating Dentist or Participating Dentist of other Delta Dental Plans who is a PPO Dentist shall accept the PPO Allowed Amount as defined in Article I, Paragraph CC, as the total amount payable for the Services provided and shall not charge or accept an additional amount for such Services to or from either Enrollee or Delta Dental. Any difference between Delta Dental's reimbursement and the PPO Allowed Amount shall be the responsibility of the Enrollee.
  2. A Participating Dentist or Participating Dentist of other Delta Dental Plans other than a PPO Dentist shall accept the Allowed Amount as defined in Article I, Paragraph A, as the total amount payable for the Services provided and shall not charge or accept an additional amount for such Services. Any difference between Delta Dental's reimbursement and the Allowed Amount shall be the responsibility of the Enrollee.
- B. Fees of Non-Participating Dentists. Payments by Delta Dental for Services provided by Non-Participating Dentists to Enrollees under this Contract shall be the PPO Allowed Amount, except as constrained by Article VI, Paragraph C. Any difference between Delta Dental's reimbursement and the Allowed Amount shall be the responsibility of the Enrollee.

- C. Payment of Fees. All payment for Services provided to Enrollees as calculated in accordance with this Article, shall be payable or otherwise discharged by Delta Dental unless constrained by deductibles, co-payments or maximums, as set forth in Schedule II, in which case fees shall be payable or otherwise discharged by Delta Dental and payable by the Enrollee in accordance with Schedule II.
- D. Prohibited Payment. Delta Dental shall not pay any claim, bill, or other demand or request for payment for Services of a Dentist that the appropriate regulatory board determines were provided as a result of a prohibited referral.
- E. Payment Ratio. Notwithstanding any other provision in this Article, the aggregate payments made in a full calendar year to PPO Participating Dentists, after all deductible and copayment provisions have been applied, on average may not be less than 80% of the aggregate payments made in that full calendar year to Premier Participating Dentists for similar services, in the same geographic areas, under their provider service contracts.
- F. No Payment for Substandard Work. Treatment which is substandard is not a covered Service as defined in the definition of Services in Article I. When Delta Dental determines that dental Services provided to an Enrollee by a Participating Dentist or are not in accordance with the standards of generally accepted dental practice, Delta Dental has no obligation to pay, nor does the Enrollee, unless and until the Services are in accordance with the standards.

#### ARTICLE VII. EXCLUSIONS AND LIMITATIONS

The Services provided for Enrollees under this Contract shall be limited as specified in Articles of this Contract and in Schedule II.

#### ARTICLE VIII. GENERAL PROVISIONS

- A. Limitation on Liability for Errors and Omissions. This Contract shall impose no liability whatsoever upon either the Company Group Plan or Delta Dental, severally or jointly, for any act or omission, including but not limited to negligence, misfeasance, malfeasance, non-feasance or malpractice on the part of a Dentist, his/her employees or agents, in the performance of dental procedures for an Enrollee.

This Contract may not be contested, except for nonpayment of Premiums, after it has been in force for two (2) years from its date of issue. A statement made by any person covered under this Contract relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two (2) years during the person's lifetime.

- B. Statements Considered Representations. Absent fraud, each statement made by the Company or Enrollee is considered to be a representation and not a warranty.

- C. Effect of Statements to Effectuate Insurance. Statements made by Delta Dental to effectuate insurance do not avoid the insurance or reduce benefits under the Contract, unless the statement is contained in a written instrument signed by the Company or Enrollee, and a copy of the statement is given to the Company, Enrollee, or beneficiary of the Enrollee.
- D. Summary of Coverage. Delta Dental will provide to the Company for delivery to each Enrollee, a brochure for each family unit that summarized the essential features of the insurance coverage of the Enrollee and indicates to whom benefits under the policy are payable.
- E. Doctor-Patient Relationship. Nothing contained in this Contract and Schedules shall be construed as meaning that the relationship between a Dentist and an Enrollee, who is his/her patient, is other than that of a generally accepted relationship of doctor and patient.
- F. Assignment. Neither party in this Contract may assign its interest herein without the written consent of the other party hereto.
- G. Governing Law and Jurisdiction. This Contract shall be governed by and construed according to the laws of Maryland and be subject to the jurisdiction of state and federal court in Maryland.
- H. Binding Nature of Contract. This Contract and the Schedules attached to it shall be binding upon each party's respective successors and assigns.
- I. Complaints. Enrollee complaints concerning carriers can be made or sent in writing to:

The Maryland Insurance Administration  
The L/H Inquiry and Investigation Unit  
525 St. Paul Place  
Baltimore, Maryland 21202  
Telephone – 410-468-2244

- J. Subrogation. Delta Dental shall notify the Company regarding any claims which, in the opinion of Delta Dental, may involve probable third-party liability, subrogation, or other litigation, and investigate or pursue such claims for recoveries. The Company shall be responsible for the investigation and prosecution of any subrogation recoveries it chooses to do beyond those deemed appropriate by Delta Dental.

Unless Delta Dental or the Company file a petition to intervene in a personal injury action and is independently represented by counsel in a subrogation claim arising out of a claim for personal injury, the amount permitted to be recovered by Delta Dental for dental benefits paid or payable on behalf of the injured person shall be reduced by an amount that is determined as follows: (i) Divide the amount of the total recovery in the claim for personal injury into the total amount of the attorney's fees incurred by the

injured person for Services rendered in connection with the injured person's claim and multiply the result by the amount of Delta Dental's subrogation claim. (ii) The product of the multiplication in subparagraph (i) of the Paragraph shall not exceed one-third (1/3) of the amount permitted to be recovered.

- K. Indemnification. Delta Dental shall indemnify and save harmless Company, its directors, officers, employees, agents, successors and assigns from any claim, cost, liability, or expense, asserted by or sustained by a person or entity not a party to this Contract, including assuming the burden and expense of defense against such claims, arising out of or resulting in financial loss or other damage because of any alleged act or alleged failure to act pursuant to this Contract or under this Contract if the alleged action or failure to take action is the responsibility of Delta Dental under this Contract.

Company shall indemnify and save harmless Delta Dental, its directors, officers, employees, agents, successors and assigns from any claim, cost, liability, or expense, asserted by or sustained by a person or entity not a party to this Contract, including assuming the burden and expense of defense against such claims, arising out of or resulting in financial loss or other damage because of any alleged act or alleged failure to act pursuant to this Contract or under this Contract if the alleged action or failure to take action is the responsibility of Company under this Contract.

- L. Company Responsibilities. Company, as applicable, shall be solely responsible for its Group Health Plan's compliance with HIPAA's administrative requirements resulting from the Company's activities, including but not limited to, privacy officer designation, training, policies and procedures pursuant to 45 C.F.R. § 164.530 etc. Company policies and procedures regarding disclosure of PHI shall permit disclosure regarding dependent only to those persons who qualify as parent or legal guardian/custodian as defined under applicable state law.

- M. Notices. Communications intended for Delta Dental shall be addressed to One Delta Drive, Mechanicsburg, PA 17055. Company shall designate in writing the name and address of a representative to receive notices from Delta Dental to Company and notices, including HIPAA notices, to Enrollees under this Contract. Company may change their representatives at any time on thirty (30) days notice to Delta Dental. The Company representative shall disseminate notices to the Enrollees within thirty (30) days of receipt, unless otherwise agreed by Delta Dental and Company, and disseminate HIPAA notices to Enrollees upon enrollment by the Company.

- N. Force Majeure. Neither Delta Dental nor Company shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control and without its fault or negligence. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, unusually severe weather or labor disputes. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

- O. Independent Contractor Status of Dentists Providing Services. Any PPO Dentists, or other Dentists, or any Dentist or employee associated with or employed by them, providing Services to Enrollees enrolled in the Delta Dental PPO program, as with other Delta Dental programs, provide such Services as an independent contractor and shall be solely responsible for dental advice and for performance of Services, or lack thereof, to the Enrollee.
- P. International Care. Enrollees can obtain dental care outside of the United States through Delta Dental's partnership with International SOS Assistance, Inc. (I-SOS). I-SOS provides referrals to Dentists and dental clinics in nearly 200 countries worldwide. English-speaking operators are available around the clock to help participants find a Dentist. Delta Dental coverage outside the United States is the same as the Delta Dental out-of-network coverage within the United States. Reimbursement is determined by the Company's specific plan design and is based on the out-of-network benefit provided through the plan. The I-SOS referral service is offered through a partnership agreement and will not be available if the agreement terminates.

#### ARTICLE IX. REPORTS AND RECORDS AND INSPECTION THEREOF

- A. Employment Information. For purposes of enrollment of Enrollees under Article II, Company shall supply to Delta Dental such information as is required by the provisions of Article II at the expense of Company. Such other employment information as Delta Dental may need from time to time for purposes of determining eligibility or preparing statistical reports shall be provided by Company to Delta Dental at the expense of Company.
- B. Records. Delta Dental shall maintain adequate records of Services provided under this Contract in order that statistical evaluations of the dental care program can be made. Such records shall be deemed the joint property of the Company and Delta Dental and neither party may release the contents of such records to third parties without the written consent of the other except as otherwise provided by law. Statistical aggregated findings based on such records may be published by Delta Dental without the consent of the Company or an Enrollee, but any such published findings will not disclose the name of the Company or Enrollee. The maintenance of all records shall comply with HIPAA and shall meet, to the extent applicable, the HIPAA identification standards in 45 C.F.R. § 164.514.
- C. Right to Audit. Notwithstanding any other provision of this Contract, provided that the standards of confidentiality set forth elsewhere in the Contract and the HIPAA Business Associate Addendum are observed, Company shall have the right to audit all of the records maintained by Delta Dental pertinent to the payment under this Contract during the normal business hours of Delta Dental after receipt by Delta Dental as of written notice of the date of the audit at least five (5) business days before the date, whether or not such information is ordinarily reported by Delta Dental to Company. Subject to the Business Associate Addendum, Company may select an independent auditor acceptable to Delta Dental (whose consent shall not be unreasonably withheld) to conduct or assist with any audit under this Contract. Company shall reimburse Delta Dental for any expense incurred by Delta Dental assisting Company in its audit.

## ARTICLE X. CONTRACT RENEWAL, MODIFICATION AND TERMINATION

- A. Renewal, Modification and Termination. This Contract shall be automatically renewed for a 12-month term under the same terms and conditions including renewal, except that the appropriate change shall be automatically made in Article I, Paragraph F, providing that present rates under such Contract have been in effect for a least 12 months, unless Delta Dental gives written notice to Company of its desire to modify, in accordance with Paragraphs H and I, of this Article or to terminate at least forty-five (45) days prior to the end of the current term.
- B. Modification due to Reduction in Size of Group. If the Prospective Rating Method or the Retention Rating Method are used pursuant to Schedule I in calculating premiums and if the number of Primary Enrollees reported by the Company to Delta Dental falls below the minimum number set in Schedule I, for three (3) consecutive months, Delta Dental may propose to Company two or more alternate adjustments in rates, benefits or co-payments in order to remedy adverse group experience which may result from such variations. Within thirty (30) days after such proposal has been sent to Company in writing, Company shall select one of the alternate adjustments by written notice to Delta Dental or, if Company fails to do so, Delta Dental may select one or more alternate adjustments in rates, benefits and/or co-payments by written notice to Company and the Contract shall thereby be modified on the date set forth in the notice.
- C. Termination on Failure to Pay Premiums. If premiums, as provided in Schedule I, after notice and billing by Delta Dental, are not paid when due after payment of the first Premium, Company shall be granted a grace period of thirty (30) days in which to remit the Premiums unless the carrier does not intend to renew this Contract beyond the period for which Premiums have been accepted and notice of the intention not to renew is delivered to the Company at least forty-five (45) days before the final Premium is due. During the grace period, the Contract shall remain in-force. Unless Delta Dental receives a notice of the Company's intention to terminate the Contract before the end of the grace period, Company shall be liable for the Premium due for the grace period. If Delta Dental receives a notice of intention to terminate the Contract during the grace period, the Company shall be liable only for the Premium for the period beginning on the first day of the grace period until the date on which notice is received or the date of termination stated in the notice, whichever is later. Failure to remit the Premiums for which the Company is liable before the end of the grace period will cause the Contract to terminate on the day following the end of the specified grace period (termination date). If Premiums for which the Company is liable are not paid during the grace period, Delta Dental shall only be obligated to pay claims as stated in Paragraphs H and I of Article IV.
- D. Reinstatement. Acceptance by Delta Dental after the termination date of the proper amount of Premiums for the period prior to the termination date, shall reinstate the Contract as though it had never been terminated. If Premium for a grace period is paid after the grace period ends, Delta Dental may charge interest for that Premium, but interest may not begin to accrue during the grace period. The interest rate charged may not exceed an effective rate of six (6) percent per year.

- E. COBRA Exception. Termination of Continuation Coverage for an Enrollee or his/her Dependents for failure to pay Premiums pursuant to Paragraph E, Subparagraph 3 of Article I, shall not be a "Termination on Failure to Pay Premiums" under Paragraph C of this Article and Paragraphs C, D, and E of this Article shall specifically not be applicable to termination of Continuation Coverage.
- F. Notification to Enrollees of Contract Termination. Any notification of Contract termination to Enrollees required by the Employee Retirement Income Security Act of 1974 shall be the responsibility of Company. Any claims incurred by Enrollees after a termination date because of lack of notice of termination shall be the responsibility of Company.
- G. Mandated Changes. If any changes in the provisions of the Contract, including changes in the Schedules or Riders attached to it, are required as a result of any applicable Federal or State laws, or regulations or orders thereunder, such changes shall automatically be incorporated into this Contract. The effective date of all such changes shall be as prescribed in the applicable law, regulations or orders. The changes shall be made in the form of a Modification to the Contract, amendment to the Schedules or substitution of new Schedules or substitution of new Riders, which after obtaining necessary government approvals, shall be promptly sent to Company for attachment to the Contract.
- H. Company Proposed Changes. If Company wishes to make changes in the covered Services, exclusions or limitations in the Contract, it shall give written notice of such proposed changes to Delta Dental. Such changes, including any resulting Premium increases or decreases, shall then be proposed by Delta Dental in the form of Modification to the Contract, amendments to the Schedules or substitution of new Schedules or Riders, approved as to form and content by the appropriate governmental authority. Such changes shall have an effective date agreed to by Company and Delta Dental. Timely payment of the Premium at the indicated rate for the period after the effective date by Company shall be deemed receipt of notice and acceptance by Company of the changes. If Company does not pay the indicated Premium for the changes, the Agreement shall continue as though changes had not been proposed.
- I. Delta Dental Proposed Changes. If Delta Dental determines that any changes in the provisions of the Contract, including the Schedules or Riders attached to it, are required or warranted, such changes shall be proposed to Company in the form and with an effective date, as described in Paragraph H of this Article at least forty-five (45) days prior to such change. The provisions of Paragraph H, concerning approval as to form and content by appropriate governmental authority, deemed receipt of notice and acceptance of changes or continuation of the Agreement, shall apply to changes proposed by Delta Dental under this Paragraph of this Article.
- J. Reduction or Elimination of Coverage. Notwithstanding anything to the contrary in Paragraphs H and I of this Article, any change in the provisions of the Contract reducing or eliminating coverage shall provide for signed acceptance of Company.
- K. Extension of Benefits. If an Enrollee's coverage terminates, an extension of benefits shall be provided in accordance with Article IV, Paragraph H.

- L. HIPAA Provision Survival. Any and all obligations related to Records maintenance and compliance with HIPAA standards shall survive termination of this Contract.
- M. Termination by Company Prior to End of Contract Term. The provisions of this Article and Paragraph F of Article I notwithstanding, Company may terminate the Contract at any time, except Company shall be liable for the Premium owed through the end of the grace period. If Company notifies Delta Dental of its intent to terminate during the grace period, Delta Dental may only hold the Company liable for the Premium for the period beginning on the first day of the grace period until the date on which the notice is received or the date of termination stated in the notice, whichever is later. The obligations of Delta Dental to pay claims shall, as of the termination date, be governed by Paragraphs H and I of Article IV. If a question arises as to whether this Paragraph or Paragraph C of this Article apply, Paragraph C of this Article shall be applicable and not this Paragraph.

#### ARTICLE XI. EXTENT OF ENTIRE CONTRACT

The Contract between the parties consists of this printed document together with Schedule I and Schedule II and any Riders attached before execution of the Contract. Any changes to the Contract shall only be made in the form of Modifications to the Contract, Amendments to the Schedules, substitutions of new Schedules or new Riders in accordance with Article X, Paragraphs G, H, I and J shall be in writing and executed by an approving executive officer of Delta Dental.

#### ARTICLE XII. CANCELLATION OF EXISTING CONTRACTS

This Contract supersedes all prior contracts existing between the parties which are inconsistent herewith.

IN WITNESS WHEREOF, the parties hereto have caused this Dental Service Contract to be executed at Mechanicsburg, Pennsylvania.

#### CHARLES COUNTY GOVERNMENT

Group # 7144

By: Wayne Cooper  
Title: President

#### DELTA DENTAL OF PENNSYLVANIA

By: [Signature]  
Title: President

Contract term: July 1, 2007 to June 30, 2008

SCHEDULE II

DELTA DENTAL PPO DENTAL SERVICE CONTRACT  
FOR EXPERIENCE RATED GROUPS

for

DELTA DENTAL OF PENNSYLVANIA

One Delta Drive  
Mechanicsburg, PA 17055

|                  |                           |                       |
|------------------|---------------------------|-----------------------|
| <u>Group No.</u> | <u>Group Name</u>         | <u>Effective Date</u> |
| 7144             | CHARLES COUNTY GOVERNMENT | July 1, 2007          |

In order to obtain the maximum benefit under this Contract, Enrollees must have Services performed by a PPO Dentist. Because PPO Dentists in the Delta Dental PPO program accept lower fees as full payment for Services than Participating Dentists who are not PPO Dentists, there will be no balance billing to Enrollees for Services performed by PPO Dentists. Balance billing to Enrollees for Services performed by Participating Dentists who are not PPO Dentists is limited to a lesser degree under this Contract. There will be no limit to the amount of balance billing to Enrollees for Services performed by Non-participating Dentists.

SECTION 1. SERVICES

Subject to the exclusions, conditions and limitations hereinafter set forth, each Enrollee hereunder shall be entitled to the following benefits **as indicated by a check in the box preceding the applicable benefit:**

A. Basic Benefits consisting of:

- ☒ 1. Diagnostic. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, procedures to assist Dentists in evaluating the existing conditions to determine the required dental Treatment.
- ☒ 2. Preventive. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, procedures to prevent the occurrence of all disease. These Services include:
  - a. Prophylaxis
  - b. Topical application of fluoride solutions
  - c. Space maintainers when used to maintain existing space
- ☒ 3. Basic Restorative. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, amalgam, synthetic porcelain and plastic restorations for Treatment of carious lesions.

- ☒ 4. Major Restorative. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, single crowns, inlays and onlays, gold or cast restorations when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.
- ☒ 5. Oral Surgery. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for extraction and other oral surgery including pre- and post-operative care.
- ☒ 6. Endodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for pulpal therapy and root canal filling.
- ☒ 7. Non-Surgical Periodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for non-surgical Treatment of disease of the gums and supporting structures of the teeth.
- ☒ 8. Prosthodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, materials and procedures for construction of bridges, partial and complete dentures.
- ☒ 9. Orthodontics. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, materials, devices and procedures for the correction of malposed teeth.
- ☒ 10. Surgical Periodontics. Provides when necessary and customary as determined by the standards of generally accepted dental practice, for surgical Treatment of disease of the gums and supporting structures of the teeth.
- ☒ 11. General Anesthesia. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for general anesthesia when administered by a Dentist for a covered oral surgery procedure.

## SECTION 2. GENERAL EXCLUSIONS AND LIMITATIONS

### A. Excluded Benefits:

- 1. Treatment or materials which are benefits to an Enrollee under Medicare or Medicaid unless this exclusion is prohibited by law.
- 2. Treatment or materials with respect to congenital skeletal malformation or Treatment of enamel hypoplasia (lack of development), except that this exclusion shall not affect eligible newborn children as described in the definition of Dependent in Article I of the Contract so long as such Dependent children continue to be eligible. When Services are not excluded under this provision as to Dependent children who continue to be eligible, other limitations and exclusions of this Schedule shall specifically apply.

3. Treatment that increases the vertical dimension of an occlusion, replace tooth structure lost by attrition or erosion, or otherwise unless it is part of a Treatment dentally necessary due to accident or injury and directly attributable thereto or a covered procedure in a Rider to this Schedule.
4. Treatment or materials primarily for cosmetic purposes including but not limited to Treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a Treatment dentally necessary due to accident or injury and directly attributable thereto. If Services are not excluded as to particular teeth under this provision, cosmetic Treatment of teeth adjacent or near the affected ones is excluded.
5. Treatment or materials for which the Enrollee would have no legal obligation to pay.
6. Services provided or materials furnished prior to the effective eligibility date of a Enrollee under this Contract unless the Treatment was a year in duration and was completed after the Enrollee became eligible except insofar as the limitations in Section 2, Subsection B, Paragraphs 2 and 5 of the Schedule do not apply.
7. Periodontal splinting, equilibration, gnathological recordings and associated Treatment and extra-oral grafts.
8. Preventive plaque control programs, including oral hygiene instruction programs.
9. Fissure sealants unless covered under a Rider to this Schedule.
10. Myofunctional therapy, unless covered by the exception in Section 2, Subsection A, Paragraph 2 of this Schedule or a covered procedure in a Rider to this Schedule.
11. Temporomandibular joint dysfunction, unless covered by the exception in Section 2, Subsection A, Paragraph 2 of this Schedule or under a Rider to this Schedule.
12. Prescription drugs including topically applied medication for Treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in Section 1, Subsection A, Paragraph 11 of this Schedule or in a Rider to this Schedule.
13. Implants and related services, unless covered by the exception in Section 2, Subsection A, Paragraph 2 of this Schedule or under a Rider to this Schedule.
14. Experimental procedures which have not been accepted by the American Dental Association.
15. Services provided or material furnished after the termination date of coverage for which Premium has been paid, as applicable to individual Enrollees or Company, except this shall not apply to Services commenced while the Contract was in effect or the Enrollee was eligible.

16. Treatment or materials provided in a hospital or any other surgical Treatment facility except as a covered benefit in Section 1, Subsection A of this Schedule.
17. Dental practice administrative services including but not limited to, preparation of claims, any non-Treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing Treatment such as cotton swabs, gauze, bibs, masks, or relation techniques such as music.
18. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

B. Benefits to Enrollees shall be limited as follows unless otherwise limited under separate Rider(s) to this Schedule:

1. Limitation on Optional Treatment Plan. In all cases in which there are optional plans of Treatment carrying different Treatment costs, payment will be made only for the applicable percentage of the least costly course of Treatment, so long as such Treatment will restore the oral condition in a professionally accepted manner, with the balance of the Treatment cost remaining the responsibility of the Enrollee. Such optional Treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.
2. Limitation on Major Restorative Benefits. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the Enrollee and the Dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the Treatment shall be considered a dental Treatment excluded from coverage under this Contract. Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this Contract, under any prior dental care contract, or by the Enrollee.
3. Limitation on Diagnostic Aids. Full mouth x-rays and panorex x-rays accompanied by bitewing x-rays are limited to once in any three-year period. Bitewing x-rays are limited to twice in any twelve-month period. Periodic examinations of the full mouth are limited to twice in any twelve-month period.
4. Limitation on Prophylaxis and Fluoride. Prophylaxes and fluoride application may be performed either together or separately. Prophylaxes are limited to twice in any twelve-month period. Fluoride applications as a benefit are limited to twice in any twelve-month period up to age 19.

5. Limitation on Prosthodontic Benefits. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances fit will be provided in accordance with the Contract. Prosthodontic appliances and abutment crowns will be replaced only after five (5) years have elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.
6. Limitation on Orthodontic Benefits. Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of Dependents up to age 19 (to the end of the calendar year), through the completion of the procedures; or to the date eligibility terminates or the Contract terminates, whichever occurs first. The obligation of Delta Dental to make monthly or other periodic payments for orthodontic Treatment will cease upon termination of Treatment for any reason, prior to completion of the procedure. Delta Dental will not make any payment for repair or replacement of orthodontic appliances furnished pursuant to the Contract.
7. Limitation on Oral Surgery Benefits. Benefits for specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth payable under a medical insurance contract or a medical or hospital service contract for which premiums are paid by the Company by which the Enrollee is covered shall be determined first under that contract. Delta Dental's obligation for these oral surgery Services shall be limited to the difference between benefits paid under the other contracts up to the Allowed Amount for the procedure less the applicable deductible and patient co-payment. When coverage is not paid for by the Company or there is no medical or hospital coverage, Delta Dental's obligation shall be subject to coordination of benefits pursuant to Article V or limited to the Allowed Amount for the procedure less the applicable deductible and patient co-payment.
8. Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this Contract, under any prior dental contract, or by the Enrollee.

C. Payments for Services to Enrollees shall be limited as follows:

1. Offset for Worker's Compensation. Services or supplies for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws shall be an offset against amounts payable under this Contract. The offset shall be credited against the obligations of Delta Dental and Enrollee in the percentages set forth in Section 2, Subsection C, Paragraph 3 of this Schedule.

2. Deductible:

a. Delta Dental shall not be obligated to pay for or otherwise discharge, in whole or in part, a deductible consisting of the first \$25.00, of fees for Services, calculated in accordance with Article VI, which are covered benefits received by an Enrollee under the Contract. Such deductible amount shall not exceed \$75.00 for all Enrollees in a single Family.

b. Such deductible amount shall apply:

|            |                                                                                                                    |
|------------|--------------------------------------------------------------------------------------------------------------------|
| <u>n/a</u> | Once each Calendar Year or portion thereof during which the Enrollee is continuously eligible under this contract. |
| <u>x</u>   | Once each Contract Year or portion thereof during which the Enrollee is continuously eligible under this Contract. |
| <u>n/a</u> | Once in the lifetime of the Enrollee.                                                                              |
| <u>x</u>   | To all benefits except the following:                                                                              |

Diagnostic, Preventive, Sealants and Orthodontics

c. Payments by Enrollees for Services which are not Contract benefits, co-payment made by Enrollees pursuant to Schedule II, Section 2, Subsection C, Paragraph 3, and payments made to Participating Dentists who are not PPO Dentists and to Non-Participating Dentists in excess of fees for Services calculated in accordance with Article VI shall not be counted in determining whether the deductible amount has been satisfied.

3. Co-Payment:

Enrollee shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible as follows:

| <u>SERVICES PERFORMED</u> |                           | <u>PAID BY DELTA DENTAL</u> | <u>PAID BY PATIENT<br/>AS CO-INSURER</u> |
|---------------------------|---------------------------|-----------------------------|------------------------------------------|
| I.                        | Diagnostic                | <u>100%</u>                 | <u>0%</u>                                |
| II.                       | Preventive                | <u>100%</u>                 | <u>0%</u>                                |
| III.                      | Basic Restorative         | <u>100%</u>                 | <u>0%</u>                                |
| IV.                       | Major Restorative         | <u>50%</u>                  | <u>50%</u>                               |
| V.                        | Oral Surgery              | <u>*%</u>                   | <u>*%</u>                                |
| VI.                       | Endodontics               | <u>80%</u>                  | <u>20%</u>                               |
| VII.                      | Non-Surgical Periodontics | <u>80%</u>                  | <u>20%</u>                               |
| VIII.                     | Prosthodontics            | <u>50%</u>                  | <u>50%</u>                               |
| IX.                       | Orthodontics              | <u>50%</u>                  | <u>50%</u>                               |
| X.                        | Surgical Periodontics     | <u>80%</u>                  | <u>20%</u>                               |
| XI.                       | General Anesthesia        | <u>80%</u>                  | <u>20%</u>                               |

\*Refer to Form R-3

4. Maximum:

- a. The maximum amount payable for benefits provided to any Enrollee as defined in Schedule II, Section 1, excluding orthodontics if it is a covered benefit and has a separate maximum amount in Subparagraph c of this Paragraph, is \$1,500.00.
- b. Such maximum amount shall apply:
  - n/a For each Calendar Year or portion thereof during which the Enrollee is continuously eligible under this Contract.
  - x For each Contract Year or portion thereof during which the Enrollee is continuously eligible under this Contract.
- c. The maximum amount payable for orthodontics for the lifetime of the Enrollee shall be \$1,500.00 whether paid for under the provisions of this Contract or under any prior dental care contract.

5. Emergency Services. When emergency Treatment is necessary and the Enrollee does not have access to a PPO Dentist, payment for such emergency Services shall be the Allowed Amount as defined in Article I, Paragraph A or the actual fees charged, whichever are less, as paid by Delta Dental and the Enrollee in accordance with Article VI, Paragraph C. Emergency Services include emergency examinations and emergency palliative Treatment to relieve acute pain. Documentation of the emergency nature of such Services including radiographs and/or a narrative from the treating Dentist may be required by Delta Dental. Should the patient receive further Services from the same treating Dentist, payment will be calculated in accordance with Article VI, Paragraph B.

D. Notification to Enrollees:

When a claim for Services is approved for payment, Delta Dental shall notify the Enrollee of the Dentist's charge, Delta Dental's calculation of the PPO Allowed Amount, and amounts for which the Enrollee is obligated to pay under this Contract.

If the Services are provided by a Participating Dentist who is a PPO Dentist, the Enrollee's obligation to pay the PPO Dentist is limited to any applicable deductible and co-payment, and any portion of the PPO Allowed Amount which exceeds applicable program maximums.

If the Services are provided by a Participating Dentist who is not a PPO Dentist, the Enrollee's obligation to pay that Participating Dentist is limited to any applicable deductible, co-payment, any difference between the PPO Allowed Amount and the Allowed Amount, as defined in Article I, Paragraph A, for the Service after application of such deductibles or co-payment, and any portion of the Allowed Amount which exceeds applicable program maximums.

If the Services are provided by a Non-Participating Dentist, the Enrollee's payment obligation to the Dentist is not limited by this Contract.

IN WITNESS WHEREOF, the parties hereto have caused this Schedule II of this Dental Service Contract to be executed at Mechanicsburg, Pa.

CHARLES COUNTY GOVERNMENT

Group # 7144

By:   
Title: President

DELTA DENTAL OF PENNSYLVANIA

By:   
Title: President

Contract Term: July 1, 2007 to June 30, 2008

## APPENDIX A

*(1) Denial of payment based upon lack of coverage of benefit under the Contract or Enrollee's eligibility status i.e. coverage decisions made pursuant to Title 15, Subtitle 10D of the Maryland Insurance Article, that are not considered Adverse Decisions under Title 15, Subtitle 10A of the Maryland Insurance Article.*

If a post-service claim<sup>1</sup> is denied in whole or in part, Delta Dental shall notify the Enrollee and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding, fifteen (15) days for processing. If there is an extension, the Enrollee and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either the Enrollee or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Enrollee or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (fifteen (15) days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by Delta Dental (without regard to whether all of the requested information is provided) or, if earlier, the due date established by Delta Dental for furnishing the requested information (at least forty-five (45) days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent Contract provisions on which the denial is based, a description of any additional material or information necessary for the Enrollee to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the Enrollee's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that were relied upon (and that a copy will be provided free of charge upon request). The notice shall also include the following statement:

**ATTN. FULLY INSURED MARYLAND ENROLLEES: "THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF**

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<sup>1</sup> Delta Dental does not condition receipt of a benefit, in whole or in part, upon approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

**THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES.** You may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at: Health Education and Advocacy Unit, Consumer Protection Division, Office of the Attorney General, 200 Saint Paul Place, 16<sup>th</sup> Floor, Baltimore, Maryland, 21202; 877-261-8807 (toll free) or 410-528-1840; [heau@oag.state.md.us](mailto:heau@oag.state.md.us). The Health Advocacy Unit can help you and your health care provider prepare a grievance to file under the carrier's internal grievance procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process. Additionally, you may file a complaint with the Maryland Insurance Administration, without having to first file a grievance with the plan, if: (1) the plan has denied authorization for a health care service not yet provided to you, and (2) you or your provider can show a compelling reason to file a complaint, including that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others. **INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN THE GROUP CONTRACT.**

If the Enrollee or the attending dentist wants the denial of benefits reviewed, the Enrollee or the attending dentist must write to Delta Dental within one hundred eighty (180) days of the date on the denial letter. In the letter, the Enrollee or attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Enrollee or the attending dentist is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to the Enrollee or the attending dentist on request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify the Enrollee and the attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send to the Enrollee or attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract provisions on which the benefit determination is based. The notice shall state that the Enrollee is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Enrollee's claim for benefits. The notice shall refer to any internal rule, guideline and protocol that were relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by either the Enrollee or the attending dentist. The notice shall also state that the Enrollee has a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance agency."

If in the opinion of the Enrollee or attending dentist, the matter warrants further consideration, the Enrollee or the attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta's Dental Affairs Committee if requested by the Enrollee or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration, or within sixty (60) working days of the initial request for review described above, whichever is sooner. The notice of decision will state the specific factual bases for the decision. It will also include the Maryland Insurance Commissioner's address, telephone number, and facsimile number, as well as a statement that the Enrollee, or his or her dentist, has a right to file a complaint with the Maryland Insurance Commissioner within 60 working days after receipt of Delta Dental's appeal decision. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the Maryland Insurance Commissioner, or to the courts with an ERISA or other civil action.

*(2) Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e. claim benefit determinations that are considered Adverse Decisions - under Title 15, Subtitle 10A of the Maryland Insurance Article.*

See Attachment One.

## **ATTACHMENT ONE**

### **DELTA DENTAL OF PENNSYLVANIA'S INTERNAL GRIEVANCE PROCEDURE**

#### **I. Definitions**

- A. Adverse Decision shall mean a utilization review determination by a Private Review Agent, a carrier, or a health care provider acting on behalf of a carrier that (1) a proposed or delivered health care service covered under the Member's contract is or was not medically necessary, appropriate, or efficient; and (2) may result in non-coverage of health care service. An Adverse Decision does not include a decision concerning an Enrollee's status as a Member.
- B. Complaint shall mean a protest filed with the Commissioner involving an Adverse Decision or Grievance Decision concerning a Member.
- C. Filing Date shall mean the earlier of five (5) days after the date of mailing or the date of receipt.
- D. Grievance shall mean a protest filed by a Member or a health care provider on behalf of a Member with Delta Dental through Delta Dental's internal grievance process regarding an Adverse Decision concerning the Member.
- E. Grievance Decision shall mean a final determination by Delta Dental that arises from a Grievance filed with Delta Dental under its internal grievance process regarding an Adverse Decision concerning a Member.
- F. Health Advocacy Unit shall mean the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of Attorney General established under Commercial Law Article, Title 13, Subtitle 4A, Annotated Code of Maryland.
- G. Health Care Provider shall mean: (1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or (2) a hospital, as defined in section 19301 of the Health-General Article.

- H. Health Care Service shall mean a health or medical care procedure or service rendered by a health care provider including: (1) testing, diagnosis, or treatment of a human disease or dysfunction; (2) dispensing drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; and (3) any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of an individual.
- I. Member shall mean a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in Maryland by Delta Dental. Member includes an Enrollee, and unless preempted by federal law, a Medicare recipient. Member does not include a Medicaid recipient.
- J. Private Review Agent shall mean: (1) a non-hospital affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of a Maryland business entity or a third party that provides or administers hospital benefits to citizens of Maryland including a health maintenance organization, a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization authorized to offer health insurance policies or contracts in Maryland; or (2) any person or entity including a hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by the hospital; or employed by a business wholly owned by the hospital.

## II. Standard Claims Procedure

- A. Processing of Claims: Delta Dental shall process all claims as expeditiously as possible. Within 30 days after receipt of a claim, Delta Dental shall either:
  - 1. Pay the entire claim or any undisputed portion of the claim;
  - 2. Send a notice of receipt and status of the claim in accordance with sections II(B) and II(C) below that states that Delta Dental denies all or part of the claim and the reason for the denial; or
  - 3. If within three (3) calendar days after receipt of the initial request for health care services, Delta Dental does not have sufficient information to make a determination, Delta Dental shall inform the attending dentist of the information necessary to make the determination.

4. Send a notice of receipt and status of the claim that states that Delta Dental will require an additional fifteen (15) days<sup>2</sup> to process the claim due to the failure of the Enrollee to submit the information necessary to decide the claim. The notice will state either that:
  - a. The legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or
  - b. That the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

The Enrollee or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information.

B. Rendering of an Adverse Decision: When Delta Dental renders an Adverse Decision<sup>3</sup> on all or part of a post-service claim<sup>4</sup>, Delta Dental shall:

1. Provide oral communication of the decision to the Enrollee and the attending dentist;
2. Document the Adverse Decision in writing after Delta Dental has provided oral communication of the decision to the Enrollee and the attending dentist.

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<sup>2</sup>The extension period (fifteen (15) days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least forty-five (45) days).

<sup>3</sup> All Adverse Decisions i.e., decisions which are based upon whether a service was medically necessary, appropriate, or efficient, shall be made by a licensed dentist, or a panel of other appropriate health care service reviewers with at least one licensed dentist on the panel.

<sup>4</sup> Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

C. Notice of Adverse Decision: Within 5 working days after the Adverse Decision has been made, Delta Dental shall send a written notice to the Enrollee and the attending dentist that:

1. States in detail in clear, understandable language the specific factual bases for the carrier's decision;
2. References the specific criteria and standards, including interpretive guidelines on which the decision was based;
3. States the name, business address, and business telephone number of the designated Delta Dental employee or representative who is responsible for Delta Dental's internal grievance process as follows:

Director, Claims Administration  
Delta Dental of Pennsylvania  
One Delta Drive  
Mechanicsburg, PA 17055  
(717) 766-8500

4. Gives written details of Delta Dental's internal grievance process and procedures as follows:

If you or your attending dentist want the Adverse Decision reviewed, you or your attending dentist must contact Delta Dental, either in writing or by calling Delta Dental's toll-free number, 1-800-932-0783. *within one hundred eighty (180) days of the date on this notice.* You should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You or your attending dentist are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Delta Dental by a licensed dentist who is neither the licensed dentist who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review shall be conducted by a licensed dentist, or a panel of

appropriate health care service reviewers with at least one dentist on the panel who is a licensed dentist. Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial Adverse Decision.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify you and your attending dentist in writing of the Grievance Decision within forty-five (45) days of the date the request is received. Delta Dental shall send you and your attending dentist a notice, similar to this notice. If in the opinion of you or your attending dentist, the matter warrants *further* consideration, you have two choices: (1) you may file an action in the courts pursuant to section 502(a) of ERISA; or (2) you may file Complaint with the Maryland Insurance Administration within thirty (30) working days after receipt of Delta Dental's Grievance Decision.

A Complaint may be filed without first filing a Grievance if you or your attending dentist can demonstrate a compelling reason to do so as determined by the Maryland Insurance Administration.

5. Includes the following information:
  - a. That, if the Enrollee is fully insured, the Enrollee or attending dentist has a right to file a complaint with the Commissioner within 30 working days after receipt of Delta Dental's grievance decision;
  - b. The Commissioner's address, telephone number, and facsimile number as follows:

Maryland Insurance Administration  
Appeal and Grievance Unit  
525 St. Paul Place  
Baltimore, Maryland 21202-2272  
1.800.492.6116 or 410.468.2000  
fax 410.468.2270

- c. The following disclosure in at least 12-point typeface, with the first sentence in bold capital typeface:

**ATTN. FULLY INSURED MARYLAND ENROLLEES: THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES.** You may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at the Office of the Attorney General, 200 St. Paul Place, 16<sup>th</sup> Floor, Baltimore, Maryland, 21202. The phone number is 877-261-8807 (toll-free) or 410-528-1840. The fax number is 410-576-6571 and the e-mail address is [heau@oag.state.md.us](mailto:heau@oag.state.md.us). The Health Advocacy Unit can help you and your health care provider prepare a Grievance to file under Delta Dental's internal grievance procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process. Additionally, you may file a Complaint with the Maryland Insurance Administration, without having to first file a Grievance with Delta Dental, if: (1) Delta Dental has denied authorization for a health care service not yet provided to you; and (2) you or your provider can show a compelling reason to file a Complaint, including that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others. **INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN YOUR GROUP CONTRACT.**

### III. Internal Grievance Procedure

- A. Informal Inquiry Option: If a claim is denied in whole or in part, an Enrollee may make an informal inquiry regarding general program, eligibility questions and Adverse Decisions by contacting Delta Dental via its toll-free number at 1-800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.

- B. Non-emergency Appeals of Adverse Decisions: In lieu of making an informal inquiry, an Enrollee or his or her attending dentist may choose to appeal the Adverse Decision. The Enrollee may do so within one hundred eighty (180) days, either by writing to Delta Dental or by calling Delta Dental at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Enrollee and the attending dentist within fifteen (15) days of the filing of the appeal. The letter or oral request for appeal should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. Both the Enrollee and the attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim.
- C. Notification of Information Necessary to Conduct the Internal Grievance Process: If Delta Dental requires information necessary to conduct the internal grievance process, Delta Dental shall notify the Enrollee and the attending dentist, in writing within five (5) working days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) working days of receipt of the partial information. Delta Dental will assist the member and health care provider in gathering the necessary information without further delay.
- D. The Review: The review shall be conducted for Delta Dental by a dental consultant who is neither the dental consultant who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. The review shall be conducted by a licensed dentist, or a panel of appropriate health care service reviewers with at least one dentist on the panel who is a licensed dentist. Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta Dental will not afford deference to the initial Adverse Decision. A clinical examination at Delta Dental's cost may be implemented, along with discussion among dentist consultants. At this point, the Enrollee may also request a hearing.

- E. Grievance Decision: Delta Dental shall make a Grievance Decision within forty-five (45) days of the date the Grievance is filed. However, Delta Dental may extend this 45-day period with the written consent of the Enrollee or the attending dentist who filed the grievance on behalf of the member. Delta Dental shall document the Grievance Decision in writing after Delta Dental has provided oral communication of the decision to the Enrollee or the attending dentist. Within five (5) days after the Grievance Decision has been made, Delta Dental shall send a written notice to the Enrollee and the attending dentist in accordance with Section IV below. The Grievance Decision shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the courts with an ERISA or other civil action, or to the Maryland Insurance Administration.
  - F. Complaints: An Enrollee or the attending dentist has a right to file a Complaint with the Commissioner within thirty (30) working days after receipt of Delta Dental's Grievance Decision.
- IV. Distribution of Information to Enrollees/Attending Dentists Upon Entry of Grievance Decision. The paragraphs below outline the contents of the Notification of Grievance Decision.
- A. Content and Notification of Grievance Decision. If after the claim is reviewed, Delta Dental continues to deny the claim, Delta Dental shall send the Enrollee or the attending dentist a notice, which contains:
    - 1. A clear statement in understandable language containing the specific factual basis for Delta Dental's decision;
    - 2. A clear statement that the notice constitutes Delta Dental's final Grievance Decision;
    - 3. Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based (without using only generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary");

4. The name, business address, and business telephone number of the designated employee or Delta Dental representative who has responsibility for Delta Dental's internal grievance process as follows:

Director, Claims Administration  
Delta Dental of Pennsylvania  
One Delta Drive  
Mechanicsburg, PA 17055  
(717) 766-8500

5. A statement that a fully insured Enrollee, or health care provider who has filed the grievance on behalf of a fully insured Enrollee, has a right to file a Complaint with the Commissioner within thirty (30) working days after receipt of Delta Dental's Grievance Decision;
6. The Commissioner's address, telephone number and facsimile number as follows:

Maryland Insurance Commissioner  
525 St. Paul Place  
Baltimore, MD 21202-2272  
1.800.492.6116 or 410.468.2000  
Fax 410.468.2270

RIDER

to

SCHEDULE II

DENTAL SERVICE CONTRACT

Group No.

Group Name

Effective Date

7144

CHARLES COUNTY GOVERNMENT

July 1, 2007

SECTION 1. SERVICES

Subject to the exclusions, conditions and limitations hereinafter set forth, each Enrollee hereunder shall be entitled to the following benefits **as indicated by a check in the box preceding the applicable benefits:**

A. Basic Benefits consisting of:

- ☒ Simple Extraction. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for removal of teeth without complication, impaction or surgery.
- ☒ General Oral Surgery. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for oral surgery including pre- and post-operative care.

SECTION 2. GENERAL EXCLUSIONS AND LIMITATIONS

C. Payments for Services to Enrollees shall be limited as follows:

Co-Payment:

Enrollee shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible, set forth in Section 2, Subsection C, Paragraph 3 of Schedule II and as modified herein.

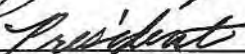
| <u>SERVICE PERFORMED</u> | <u>PAID BY DELTA DENTAL</u> | <u>PAID BY PATIENT<br/>AS CO-INSURER</u> |
|--------------------------|-----------------------------|------------------------------------------|
| Simple Extraction        | <u>100%</u>                 | <u>0%</u>                                |
| General Oral Surgery     | <u>80%</u>                  | <u>20%</u>                               |

In all other respects the above referenced Contract shall be in full force and effect.

CHARLES COUNTY GOVERNMENT

Group # 7144

By: 

Title: 

DELTA DENTAL OF PENNSYLVANIA

By: 

Title: President

Contract term: July 1, 2007 to June 30, 2008

RIDER

to

SCHEDULE II

DENTAL SERVICE CONTRACT

Group No.

Group Name

Effective Date

7144

CHARLES COUNTY GOVERNMENT

July 1, 2007

SECTION 1. SERVICES

Subject to the exclusions, conditions and limitations in Schedule II and as modified herein, each Enrollee shall be entitled to the following benefits:

A. Basic Benefits Consisting of:

Adult Orthodontics. Provides for procedures performed by a licensed dentist and involving the use of an active appliance and post-treatment retentive appliances for the Treatment of malalignment of teeth and/or jaws which significantly interferes with their function.

SECTION 2. GENERAL EXCLUSIONS AND LIMITATIONS

A. Excluded Benefits:

Devices and procedures for the correction of malposed teeth, except as a covered benefit in Section 1, Subsection A of this Rider, or except where Orthodontics are a covered benefit in Section 1, Subsection A of Schedule II.

B. Benefits to Enrollees shall be limited as follows:

Limitation on Orthodontics Benefits. If Orthodontics are a benefit under Section 1, Subsection A of Schedule II, the Limitations on Orthodontics, found in Section 2, Subsection B of Schedule II shall be modified to the extent that the services described therein are a covered benefit in Section 1, Subsection A of this Rider.

C. Payments for Services for Enrollees shall be limited as follows:

Co-Payment:

Enrollees shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible, as follows:

| <u>SERVICE PERFORMED</u> | <u>PAID BY DELTA DENTAL</u> | <u>PAID BY PATIENT<br/>AS CO-INSURER</u> |
|--------------------------|-----------------------------|------------------------------------------|
| Adult Orthodontics       | <u>50%</u>                  | <u>50%</u>                               |

Maximum:

The maximum amount payable provided to any Enrollee for Adult Orthodontics for the lifetime of the Enrollee shall be \$1,500.00.

In all other respects the above referenced Contract shall be in full force and effect.

CHARLES COUNTY GOVERNMENT

Group # 7144

By: Wayne Cropper

Title: President

DELTA DENTAL OF PENNSYLVANIA

By: A. J. Rul

Title: President

Contract term: July 1, 2007 to June 30, 2008

RIDER

to

SCHEDULE II

DENTAL SERVICE CONTRACT

Group No.

Group Name

Effective Date

7144

CHARLES COUNTY GOVERNMENT

July 1, 2007

SECTION 1. SERVICES

Subject to the exclusions, conditions and limitations in Schedule II and as modified herein, each Enrollee shall be entitled to the following benefits:

A. Basic Benefits Consisting of:

- a. Sealants. Provides, when necessary and customary as determined by the standards of generally accepted dental practice, for topically applied acrylic, plastic or composite material (fissure sealants) to prevent decay and ingress of food particles in permanent, posterior teeth.

SECTION 2. GENERAL EXCLUSIONS AND LIMITATIONS

A. Excluded Benefits:

9. Fissure sealants except as a covered benefit in Section 1, Subsection A of this Rider.

B. Benefits to Enrollees shall be limited as follows:

Limitation on Sealants. Application of sealants as a benefit is limited to dependents up to age 14 through the completion of the procedure or the date eligibility terminates, whichever occurs first. Treatment with sealants as a covered service is limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.

Limitation on Occlusal Restorations. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered services under Section 1, Subsection A, Paragraph 3 of Schedule II. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of Delta Dental shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant under Section 1, Subsection A, Paragraph entitled Sealants of this Rider.

C. Payments for Services to Enrollees shall be limited as follows:

Co-Payment:

Enrollees shall pay a proportionate share of the fee as calculated in accordance with Article VI, after application of the deductible, as follows:

| <u>SERVICE PERFORMED</u> | <u>PAID BY DELTA DENTAL</u> | <u>PAID BY PATIENT<br/>AS CO-INSURER</u> |
|--------------------------|-----------------------------|------------------------------------------|
| Sealants                 | <u>100%</u>                 | <u>0%</u>                                |

In all other respects the above referenced Contract shall be in full force and effect.

CHARLES COUNTY GOVERNMENT  
Group # 7144

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

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

DELTA DENTAL OF PENNSYLVANIA

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

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

Contract Term: July 1, 2007 to June 30, 2008

## DELTA DENTAL

### Processing Policies

In order to standardize communication, we have indexed a number of explanatory statements and policies applicable to claims processing by Delta Dental. Some of these services or procedures are excluded under all contracts, and some are specific to certain purchasers' contracts and some are specific to procedures and/or eligibility for individual Enrollees.

Completion of claim form is not a service benefited by the program. The patient may not be charged for this service.

A charge for failure to keep a scheduled appointment is not a covered benefit.

3. Full-mouth x-rays are a benefit once in a three-year period. Panoramic plus bitewings are considered a full-mouth series.

4. Panoramic or full mouth x-rays, plus bitewings are considered a full-mouth series.

This procedure is a benefit no more than once in any six-month period.

Under this dental care program prosthodontic appliances, bridges, crowns and jackets are a benefit once only in any five-year period.

Specialized techniques involving gold, precision partials, bridge attachments, personalization of characterizations are considered optional and, if provided, should be done with the agreement of the patient to assume the additional cost.

If the dentist and the patient select the two denture technique, treatment or temporary denture followed by a permanent denture, Delta Dental shall be obligated to pay only its applicable percentage of fees for Prosthodontic benefits up to a maximum for a permanent denture. The remaining costs shall be the obligation of the patient.

Payment is made for one restoration in each tooth surface irrespective of the number of restorations placed in that surface.

5. Allowance has been made for an amalgam restoration. Composite resins or acrylic restorations in posterior teeth are considered optional and, if provided, should be done with the agreement of the patient to assume the additional cost.
11. Initial exam limited to once in 12 months. Benefit based on periodic exam.
1. Amalgam or acrylic build-ups are considered part of the preparation for the completed crown, except in special circumstances and by report. This procedure is considered related to a later crown. Please submit with completed crown.

13. Delta Dental programs provide amalgam and composite restoration in connection with treatment of caries. If the tooth can be restored satisfactorily with such materials, gold restorations, crowns and jackets are considered optional, and, if provided, should be done with the agreement of the patient to assume additional cost.

14. Facings posterior to second bicuspid are considered cosmetic dentistry. An allowance has been made for a full-cast crown if facings are used. The services should be provided only with the agreement of the patient to assume the additional cost.

15. Prescription drugs, premedications and relative analgesia are not covered benefits of this dental program and the cost is the obligation of the patient.

16. General anesthesia is not a covered benefit of this dental care program for the service performed.

17. Charges for hospitalization, including hospital visits is not a covered benefit under this dental care program and the cost is the obligation of the patient.

18. Sealants are not a covered benefit under this dental care program.

19. Plaque control programs, including oral hygiene and dietary instruction are not covered benefits under this dental care program.

20. Procedures to correct congenital or developmental malformations are not a covered benefit under this dental care program.

21. Procedures, appliances or restorations primarily for cosmetic purposes are not covered benefits of this dental care program.

22. Orthodontic services, including tooth guidance appliances are not a covered benefit under this dental care program.

23. Prosthodontic services, including bridges are not a covered benefit under this dental care program.

24. Increasing vertical dimension is not a covered benefit.

25. Replacing tooth structure lost by attrition is not a covered benefit.

26. Realignment of teeth is not a covered benefit.

27. Periodontal splinting is not a covered benefit.  
Gnathological recordings are not a covered benefit.
29. Equilibration is not a covered benefit.  
Treatment of disturbances of the Temporomandibular Joint is not a covered benefit.
31. Payment is based on the latest accepted usual, customary and reasonable level; adjustment has been made accordingly. The patient of a Delta Dental participating dentist is not liable for any difference beyond contract co-payment.  
Benefits for portions of this program are based on a schedule of allowances.  
Patient is not eligible for benefits due to termination of coverage.
34. Patient is not eligible for benefits due to the treatment having been performed prior to contract's effective date.
35. Patient is not eligible for benefits due to treatment having been performed prior to employee's effective date.  
Eligibility for benefits are limited by age of the patient.
37. Service is not covered benefit of the Enrollee's dental care program.
38. Payment is based on the dentist's latest accepted fee filing; adjustment has been made accordingly. The patient of a Delta Dental participating dentist is not liable for any difference beyond contract co-payment.
39. The patient's maximum benefit has been used for this contract period.
40. Benefit allowance for polishing of restorations is included in the total allowance for this procedure.  
Deleted services are covered under another provision of your Welfare Fund.  
This service was performed during a strike period or an employment cessation period.
43. Under this group contract, patient must have a certain number of continuous months of eligibility for dental care before Prosthodontics (including bridges) become a benefit.
44. No claim will be accepted by Delta Dental unless submitted within one year of the date that services were performed according to the contract benefit.
45. The patient is not covered under the Enrollee's benefit plan.
46. An adjustment has been made for two or more surfaces which are normally joined together.  
The allowance for this procedure includes other procedures submitted which were combined for processing.  
Processed according to dental consultant's evaluation of benefits.
49. Duplicate services, or services previously predetermined on another claim.
50. Patient exceeds age limitation for benefit of topically applied fluoride. If provided, the patient is responsible for the additional cost.
51. Bitewings x-rays for this benefit plan are a benefit once in 12 months.
52. This is an adjustment to a previously processed claim.
53. This is an orthodontic benefit.
54. The payment was subject to coordination of benefits.
55. Delta Dental's liability for this claim is not computer printed on a per line basis.
56. Periodontal scaling and root planning, when provided on the same day as prophylaxis, is essentially a duplication of services. Payment will be made according to the more complex procedures.
57. Processed according to alternate course of treatment provision in contract.
58. (Not in use at this time)
59. Since a space maintainer was provided previously, this is the only additional replacement maintainer that will be paid for by Delta Dental.
60. Routine post-operative visits are considered part of and included in the benefit for the total surgical procedure. A separate fee may not be charged to the patient.
61. Porcelain, porcelain fused to metal or plastic processed to metal crowns are not a benefit for children under 12 years of age. If provided, the parent is responsible for the additional cost.
62. Delta Dental does not make a separate allowance for a bridge when a partial has been allowed in the same arch, nor will it allow a partial denture if a bridge has been allowed in the same arch, unless the dental condition (e.g. additional tooth loss) has materially changed.
63. Patient is not eligible because treatment after termination of contract.
64. Fixed bridges and/or removable cast partials are not a benefit for patients under 16. If provided, the parent is responsible for the additional cost. An allowance is made for a space maintainer.
65. Please submit a separate claim when ready to reline dentures.
66. Surgical periodontal procedures are not a covered benefit of this dental program.
67. (Not in use at this time.)
68. Records indicate same surface of tooth restored within last 24 months. Report of extenuating circumstances may be directed to benefit services for consideration.

69. This procedure is a benefit no more than twice in any 12-month period.
  1. Professional review of records submitted does not support a procedure which qualifies as a covered benefit.
  1. In the absence of the requested information, a benefit determination cannot be made at this time.
72. Please submit a post-operative x-ray of completed root canal therapy when requesting payment.
73. Enrollee was late entrant to program. Patient is not eligible for procedure performed.
74. Claim cannot be processed, because patient's eligibility cannot be verified. Enrollee should contact plan sponsor.
5. Final orthodontic payment based on the maximum specified in the enrollee's group dental contract.
5. Under this group's contract, patient must have a certain number of continuous months of eligibility for dental care before major restorations become a benefit.
7. This procedure is a benefit no more than once in any five-year period.
78. This procedure is a benefit no more than once in five months for this benefit plan.
79. The benefit on this claim has been adjusted due to previous claim overpayment.
  1. The service exceeds the required frequency limitation of 12 months.
  1. Continuation coverage eligibility cannot be verified.
82. Our records indicate that this tooth has been previously extracted.
  3. This procedure is a benefit no more than once in any thirty days.
  4. This procedure is a benefit no more than once in any ninety days.
85. This procedure is a benefit no more than once in a four-year period.
86. This procedure is a benefit no more than once in a three-year period.
  7. This procedure is a benefit no more than once in a two-year period.
  3. This procedure is a benefit no more than four times in any twelve-month period.
89. This procedure is a benefit no more than four times in a calendar year.
90. This procedure is a benefit no more than three times in any twelve-month period.
91. This procedure is a benefit no more than twice in a calendar year.
92. This procedure is a benefit no more than once in a calendar six-month period.
93. This procedure is a benefit no more than once in any calendar year.
94. This procedure is a benefit only once per lifetime.
95. This is a monthly orthodontic benefit.
96. This is a quarterly orthodontic benefit.
97. Final orthodontic benefit for this treatment.
98. Final orthodontic payment for this phase, based on the previous carrier benefit.
99. This is an orthodontic benefit for initial workup.
100. Benefits were determined as per the non-duplication clause in your group's dental contract.
101. The group has a non-duplication provision which limits secondary payment. The actual payment may be less than the amount estimated.
102. Pulp caps, when done on the same date of service as a final restoration, considered part of that completed service.
103. Diagnostic casts, when done on the same date of service as a more complex procedure, considered part of that completed service.
104. Prophylaxis, when done on the same date as a periodontal cleaning, considered part of the more complex procedure.
105. Crown buildups, when done on the same date as a post and core, considered part of the post and core.
106. A sedative filling, when performed on the same date as a pulp cap, considered part of the pulp cap.
107. Inlay, when reported on the same tooth/date as an onlay, considered part of the onlay.
108. Consultation, when reported on the same date as services other than diagnostic, considered to be an examination.
109. Routine examination, when reported on the same date as a periodontal examination, considered to be part of the more complex procedure.
110. Retention pins, when done on the same date as a crown buildup or post and core, considered part of the completed procedure.
111. Claim submission required within six months of when the services were performed.
112. Allowance has been made toward the permanent appliance, as implants are not covered.
113. This service is one, which should be submitted to the medical carrier for handling.
114. The procedure predetermined may be subject to specific benefit changes that are scheduled to occur. Please contact our office for specific dated information.

115. The actual payment may be less than the amount estimated due to primary payment.
16. Full-mouth x-rays are a benefit once in a twenty-four month period. Panoramic plus bitewings are considered a full-mouth series.
17. This service has been re-evaluated, and the initial determination has been upheld by our dental consultant.
18. Claim submission required within three months after the contract year ends.
19. Benefit reflects a portion of Delta Dental's liability. Pending continued eligibility, additional benefits will automatically be issued in approximately twelve (12) months.
20. The costs for infection control procedures are routinely included with fees for services rendered and not billable as a separate procedure.
21. This procedure is a benefit no more than three times in a calendar year period.
122. Patient is not eligible for benefits due to termination of group contract.
123. Service provided exceeds frequency limitations and in the case of a participating doctor is not billable to the patient.
24. Our records indicate eligibility under this specific group number cannot be verified. Please contact our office if you feel research is needed.
25. Under this dental care program prothodontic appliances, bridges, crowns and jackets are a benefit once only in any three-year period if services are provided by a participating doctor.
126. This procedure is a benefit no more than three in a ninety-day period.
27. This procedure is a benefit no more than twice in any six-month period.
28. The Enrollee has chosen a prepaid program that does not require a claim form.
129. This procedure is a benefit no more than twice in a twelve-month contract period.
130. This procedure is a benefit no more than once in a one-year period.
31. The actual amount payable may differ at the time service is reported due to annual maximum and deductible application.
32. This procedure is a benefit no more than four in a six-month period.
33. This procedure is a benefit no more than once in a 365-day period.
134. Patient is not eligible because treatment was performed after termination of division.
35. Therapeutic Pulpotomy is limited to primary teeth. If provided on permanent teeth, the benefit is denied.
136. If a Gingivectomy or Gingivoplasty is performed in conjunction with the preparation of a crown or other restoration, the fee is disallowed and is not billable to the patient.
137. Alveoloplasty is included in the fee for surgical extractions and is not billable to the patient.
138. This procedure is a benefit no more than twice in any contract period.
139. Dates of service performed prior to the group subdivision's effective date.
140. This procedure is a benefit no more than four times in a contract year.
141. Orthodontics is not a covered benefit.
142. This procedure is a benefit no more than once every two and a half months.
143. Benefits could not be determined because the submitted procedure code is not recognized. Upon receipt of a new claim with complete itemized procedure information, the submitted services(s) will be processed.
144. A post and core is a benefit in anterior teeth only when there is insufficient tooth structure to support a cast restoration.
145. The procedure code submitted has been changed to an authorized code for processing. Specialized techniques, personalization or characterizations are considered optional and, if provided, should be done with the agreement of the patient to assume the additional cost.
146. An amalgam/composite restoration is not a benefit when performed after a post and core has been inserted.
147. Invisalign is a non-covered benefit.
148. Under this group's contract, patient must have a certain number of continuous months of eligibility for dental care before endodontics becomes a benefit.
149. Under this group's contract, patient must have a certain number of continuous months of eligibility for dental care before periodontics becomes a benefit.
150. Under this group's contract, patient must have a certain number of continuous months of eligibility for dental care before oral surgery becomes a benefit.
151. Restoration of a tooth that has previously had a crown placed is not an allowed benefit.
152. A manual calculation has been performed on this service because a previous allowance on a temporary crown was paid.
153. This procedure is considered to be part of a completed service and is not separately chargeable. In the case of a par doctor the procedure is not billable to the patient.
154. Dentist's license was not valid during date of service on claim.

155. Under this group's contract, patient must have a certain number of continuous months of eligibility for dental care before orthodontics can become a benefit.
156. Claim submission must be within three months of when the services were performed.
- 7.\* In accordance with Federal regulations, this notice will serve as denial of this claim while necessary information is being obtained to resume processing. Once Delta Dental is in receipt of all necessary information the claim will automatically be processed as a new claim.
- \*8.\* In accordance with Federal regulations, this notice will serve as denial of this claim while necessary information is being obtained to resume processing. Once Delta Dental is in receipt of all necessary information the claim will automatically be processed as a new claim.
- 9.\* In accordance with Federal regulations, this notice will serve as denial of this claim while necessary information is being obtained to resume processing. Once Delta Dental is in receipt of all necessary information the claim will automatically be processed as a new claim.
- 10.\* In accordance with Federal regulations, this notice will serve as denial of this claim while necessary information is being obtained to resume processing. Once Delta Dental is in receipt of all necessary information the claim will automatically be processed as a new claim.
- 161.\* In accordance with Federal regulations, this notice will serve as denial of this claim while necessary information is being obtained to resume processing. Once Delta Dental is in receipt of all necessary information the claim will automatically be processed as a new claim.
12. This line of service represents interest due on this claim in accordance with Federal regulations as they relate to timely processing of insurance claims.
13. An alternate benefit has been made for a conventional abutment crown. Patient is responsible to the submitted fee for implant supported crown, which is not a benefit of this plan.
14. Submission of more than eight periapicals on the same date of service will be benefited as a complete series.
15. Root planning is not considered a separate benefit when performed on the same day as osseous surgery.
166. Gingival Curettage is no longer a valid code; we will make the allowance for Root Planing and Scaling.
167. Monthly submissions are not required. Payments will be automatically issued.
18. This plan limits benefits for conditions which existed prior to an effective date.

Numbers 157-161 repeat for internal purposes.

- \*19. Benefits have been adjusted in accordance with the guidelines within the purchased group plan.

170. This procedure is a benefit no more than three times in a contract year.
171. This procedure is a benefit only twice per lifetime.
172. Dollar amounts noted reflect adjustments.
173. After initial banding, payments for monthly orthodontic adjustments will be generated automatically subject to the patient's eligibility and contract maximum.
174. After initial banding, payments for quarterly orthodontic adjustments will be generated automatically subject to the patient's eligibility and contract maximum.
175. After initial banding, a payment for the second half payment will be generated automatically in 12 months subject to the patient's eligibility and contract maximum.
176. This procedure is a benefit that should be submitted to the medical carrier.
177. Adult Orthodontics is not a covered benefit for Spouses.
178. This procedure is a benefit only three times per lifetime.
179. Initial banding payment, monthly submissions are required to continue Orthodontic payments.
180. A one time payment will be made on this case once the pre-determination is returned subject to the patient's eligibility and contract maximum.
181. After initial banding, payments will be automatically generated every 6 months subject to the patient's eligibility and contract maximum.
182. This procedure is a benefit no more than 3 times in a 6 month period.
183. Under this group contract, patient must have a certain number of continuous months of eligibility for dental care before basic restorative becomes a benefit.
184. This claim has been denied. Our records indicate that the provider identification and/or the billing information on this claim is not current. Please submit a new claim with updated information.
185. This service has been re-evaluated, and the initial determination has been upheld.
186. Under this group contract, dependents over the age of 19 not enrolled as a full-time student, or a verified disabled dependent are not eligible for benefits.
187. A benefit determination cannot be made at this time. Please resubmit with a narrative for this procedure.
188. Our records indicate that Delta Dental is the secondary carrier for this patient. Please submit a new claim with a copy of notice of payment or denial from the primary carrier. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.

189. Our records indicate that Delta Dental is the secondary carrier for this medical procedure. Please resubmit a new claim with a copy of notice of payment or denial from the primary carrier. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.
190. Benefits for this procedure cannot be provided at this time. Please resubmit a new claim form for procedure(s) with pre-operative radiographs. Upon receipt, the claim will be processed promptly. Please note; duplicate radiographs will not be returned unless specifically requested. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.
191. Benefits for this procedure cannot be provided at this time. Please resubmit a new claim form for procedure(s) with a current full mouth x-ray. Upon receipt, the claim will be processed promptly. Please note; duplicate radiographs will not be returned unless specifically requested. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.
192. Benefits for this procedure cannot be provided at this time. Please resubmit a new claim form for procedure(s) with patient's name and current dated periodontal charting (within one year of services). Upon receipt, the claim will be processed promptly. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.
193. Benefits for this procedure could not be determined because of missing information. Upon receipt of a new claim with arch, quadrant, tooth number and/or surface code information, the submitted service(s) will be processed
194. A benefit determination cannot be made at this time. Previous carrier information is required. Please provide a new claim form with EOB's and payment information from your prior carrier. Upon receipt, claims(s) will be processed promptly.
195. Benefits could not be determined because of missing orthodontic information. Upon receipt of a new claim with the date appliance(s) were placed, initial banding fee, monthly treatment fees, and estimated number of months of treatment the submitted service(s) will be processed.
196. A benefit determination cannot be made at this time. Please provide a new claim form with a treatment narrative. Upon receipt, claim will be processed promptly. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.
197. This service/replacement exceeds the frequency limitation as defined in the patient's program. The patient is responsible for the fee.
198. Benefits for this procedure could not be determined at this time. Please submit a recent, dated pre-operative radiograph along with a new claim for the procedure. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.
199. Benefits for this procedure could not be determined because it was submitted without a narrative report. Please submit a new claim with a narrative for this procedure. Please include all attachments with new claim, i.e. explanation of benefits, periodontal charting and x-ray's.

201. Unfortunately we were unable to read necessary information on this claim because it was illegible. Upon receipt of a new claim with legible information, we will process the submitted service(s).
202. Benefits could not be determined because of missing dependent information. Upon receipt of a new claim with the full time student's school name and location, the submitted services(s) will be processed.
259. The procedure code has been changed by Delta Dental for processing purposes only.
266. The legislated %5 Massachusetts Discount has been applied.
300. Claims with dates of service prior to 11/01/05 must be submitted for payment by 01/31/06 due to a contract change.
301. Claims with dates of service prior to 01/01/06 must be submitted for payment by 07/01/06 due to a contract change.

The processing policies listed below were created to show which month the claim should be extracted for processing.  
(For example: 801 = January, 802 = February and so on.)

801. This is Delta Dental's installment payment for this orthodontic case.
802. This is Delta Dental's installment payment for this orthodontic case.
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809. This is Delta Dental's installment payment for this orthodontic case.
810. This is Delta Dental's installment payment for this orthodontic case.
811. This is Delta Dental's installment payment for this orthodontic case.
812. This is Delta Dental's installment payment for this orthodontic case.