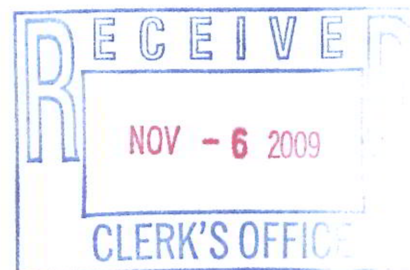
Clerk's Contract and Agreement Cover Page

Year:	2010	**Legistar File ID#:**	2009-0481
Multi Year:	☐	**Amount**	$55,000.00

Contract Type:	Professional Services
Contractor's Name:	Horton Group
Contractor's AKA:	
Execution Date:	1/1/2010
Termination Date:	12/31/2010
Renewal Date:	12/31/2010
Department:	Administration/Village Manager
Originating Person:	Stephana Przybylski

Contract Description: 2010 Employee Insurance - Medical, dental, VSP, Horton



Friday, November 06, 2009

SERVICE RETAINER AGREEMENT

This Agreement is made this **29th Day of October, 2009**, between **The Village of Orland Park** of **14700 Ravinia Avenue Orland Park, IL 60462-3167**, hereinafter referred to as **The Village of Orland Park**, and THE HORTON GROUP, INC. of 10320 Orland Parkway, Orland Park, IL 60467 hereinafter referred to as "Horton".

WHEREAS, Horton, together with its affiliated entities (its "Affiliates"), operates insurance agencies and related businesses which procure numerous lines and types of insurance products and provide various related services to accounts located throughout the areas of the United States in which Horton and such Affiliates may operate, from time to time; and

WHEREAS, **The Village of Orland Park** desires to engage Horton to provide certain benefit services in exchange for the fees as outlined in this Agreement.

NOW, THEREFORE, the parties hereto agree as follows:

1. The term of this Agreement shall commence as of **January 1, 2010**, and shall remain in effect for a period of **twelve (12) months** thereafter ending on **December 31, 2010**, unless earlier terminated as hereinafter provided.

2. Complete fee structure by service category is **illustrated in the attached Fee-Based Pricing Proposal. The fee for the twelve (12) month period January 1, 2010 through December 31, 2010 is $55,000.**

3. The Service Retainer is in lieu of standard agent commissions normally paid to Horton by the insurance carriers involved. Any standard agent commissions received by Horton shall be credited by Horton against past due and future installments of the Service Retainer. The credits shall be reflected at the end of the 12-month term.

   Horton may receive additional compensation from the insurance companies, in the forms of, including but not limited to, contingent commission or bonus commission. Upon request, Horton is pleased to disclose all compensation amounts as well as any other contingent or similar agreements that may be in place.

4. The Service Retainer shall be compensation for the services **illustrated in the attached Fee-Based Pricing Proposal.**

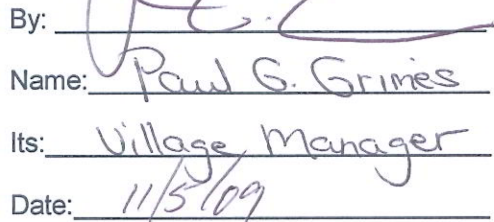
5. Agreed to and included services only apply to those coverages and policies included within the Broker appointment to Horton evidenced by a fully executed broker-of-record letter(s) and not otherwise excluded or offered as an option(s) to be separately negotiated. They include:

   a. **Medical**
   b. **RX**
   c. **Dental**
   d. **Vision**
   e. **Life/AD&D**
   f. **Flexible Spending Account**

6. It is understood that this Service Retainer Agreement is open to review at any time by either party. It is also understood that in the event Horton's retention is terminated by **The Village of Orland Park** within 90 days of the inception of the insurance policy or contract, all unearned amounts of the Service Retainer previously paid to Horton will be refunded to **The Village of Orland Park** based on a pro rata calculation on the effective date of termination. It is also understood that in the event Horton's retention is terminated by **The Village of Orland Park** after 90 days of the inception of the applicable insurance policy or contract, all fees outlined in the Service Retainer Agreement are fully earned and shall become immediately due and payable.

7. The Service Retainer Agreement covers only those specifically listed services in the attached Fee-Based Pricing Proposal and only those operations currently insured by the insurance program to be serviced under this agreement. Fees for additional services requested or required by **The Village of Orland Park** shall be separately negotiated.

THE VILLAGE OF ORLAND PARK



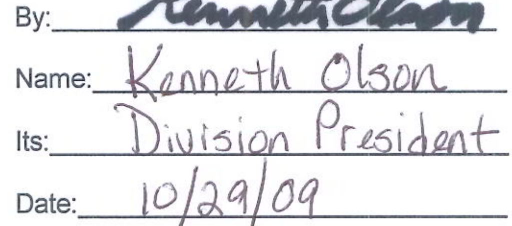
By: ____________________

Name: Paul G. Grimes

Its: Village Manager

Date: 11/5/09

THE HORTON GROUP, INC.



By: Kenneth Olson

Name: Kenneth Olson

Its: Division President

Date: 10/29/09

The Horton Group is an Equal Employment Opportunity Employer

THE VILLAGE OF ORLAND PARK
Fee-Based Pricing Proposal

Our proposed service charges are as follows:

Core Services	
Benefit Consulting and Brokerage Support, Benefit Plan Marketing, Plan Installation, Local Enrollment Meetings, Document Review and Compliance, Ongoing Administrative Client and Employee Customer Service	***$55,000 Annual Fee*** ***Payable on a quarterly basis in four (4) equal installments***
Special Services	
Call Center Assistance (Claims, Billing, Eligibility) Benefit News Alerts	***Included in Core Services***
Financial	
Mid-Year Plan Performance -Benchmark Reporting and Reviews (with standard data provided by carriers)	***Included in Core Services***
Expanded Consulting	
Contribution Modeling	***Included in Core Services***
Wellness/Prevention/Education	
Health Fair Coordination (major locations) Includes preparation and coordination of carriers and vendors. Can be combined with consumer driven educational meetings.	***Included in Core Services. Outside vendor expenses to be discussed / considered at the time services arranged / performed. Travel expenses beyond 150 miles are covered by customer***
On-Site Health Assessments Flu Shots	***Direct cost from vendor.*** ***No additional Horton fee assessed.***
Annual Employee Benefit Statements	***Included in Core Services***
Monthly Wellness Newsletters supplied electronically	***Included in Core Services***
H.R. Connect (Employee Portal) My Wave (Employer Portal)	***Included in Core Services***
Open Enrollment	
Onsite Group Enrollment (major locations)	***Included in Core Services***
On-Line Enrollment Capabilities	Varies by vendor – bid solely on vendor capabilities and costs – no additional Horton fee assessed
Webinar and 1-800 Conference Call Based Enrollment Meetings	Employer provides Webcast

BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

(Applicable to 151-Plus Insured Group Accounts)

Employer Account Number: 206338   Employer Group Number(s): H06652,P06652 PPO,P06870 HSA,P07366 HSA

Section Number(s): 0512,1510,2510,8510,0812,1812,2812,8812

Employer Name: Village of Orland Park

(Specify the employer, the employee trust or the association applying for coverage. List subsidiary or affiliated companies to be covered below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

Address: 14700 Ravinia Avenue   City: Orland Park   State: IL   Zip Code: 60462

Billing Address *(if different from above)*: _____   City: _____   State: _____   Zip Code: _____

Employer Identification Number ("EIN"):

Subsidiaries: _____

Affiliated Companies: _____

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this BPA.)

Administrative Contact: Stephana Przybylski   Phone: 708-403-6166   Fax : 708-349-4859   Email: sprzybylski@orlandpark.il.us

Blue Access for Employers (BAE) Contact: Stephana Przybylski

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: Phone: 708-403-6166   Fax: 708-349-4859   Email: sprzybylski@orlandpark.il.us

Policy Effective Date: January 1, 2010   Policy Anniversary Date: December 31, 2010

ERISA Plan: ☐ Yes ☒ No   If Yes, specify ERISA Plan Year: _____

ERISA Plan Administrator: _____

ERISA Plan Administrator's Address: _____

City: _____   State: _____   Zip Code: _____

ERISA Plan Administrator's Email: _____

ELIGIBILITY

1. Eligible Person means:

   ☐ A full-time employee of the Employer.

   ☐ A full-time employee who is a member of: _____ (name of union or association)

   ☒ Other (please specify): Full-time employees, retiress and disabled police officers; retired and disabled members of IMRF, elected officials

   Full-Time Employee means:

   ☒ A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.

   ☐ Other (please specify): _____

   ☐ An Eligible Person may also include a retiree of the Employer. Please specify: _____

2. Domestic Partner Coverage: ☐ Yes ☒ No

   If Yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner-coverage.

Domestic Partner Coverage Continuation (only available if Domestic Partners are covered) ☐ Yes ☐ No

3. Limiting Age for covered unmarried children is:

   ☒ twenty-six (26) years; thirty (30) years if eligible military personnel as described in the Certificate Booklet.

   ☐ years; years if eligible military personnel as described in the Certificate Booklet.

   (The minimum allowable ages for this option are 26; 30 if eligible military personnel)

   ☐ years if a full-time student.

   (The minimum allowable ages for this option are 26; 30 if eligible military personnel)

   Coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

4. Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

   ☒ The date of employment.

   ☐ The _____ day of employment.

   ☐ The _____ day of the month following _____ month(s) or _____ days of employment.

   ☐ The _____ day of the month following the date of employment.

   ☐ Other (please specify): _____.

5. Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and /or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage.

   Annual Open Enrollment: ☒ Yes ☐ No

   If Yes, specify Annual Open Enrollment Period: The month of November for a January 1st effective date. An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Annual Open Enrollment Period. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

6. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:

   Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 days

   (However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.)

FUNDING ARRANGEMENT

☐ Standard Premium – Prospective

☐ Standard Premium – Retrospective

☐ Minimum Premium Program (MPP)

☒ Cost Plus Program

☐ Contingent Premium - Separate Agreement

STANDARD PREMIUM INFORMATION

(a) Premium Period:

   ☐ The first day of each calendar month through the last day of each calendar month. <u>(This option applies to all coverages if the Employer has BlueCare® Dental HMO coverage)</u>

   ☐ The _____ day of each calendar month through the _____ day of the next calendar month. <u>(This option is not available for any coverage if the Employer has BlueCare Dental HMO coverage.)</u>

(b) Employer contribution:

☐ 100% of the Individual Coverage Premium and an amount equal to 100% of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.

☐ _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.

☐ Other (please specify): _____.

(c) It is understood that no Policy will be issued or renewed on a contributory basis unless at least _____% of the Eligible Persons, and for Family Coverage _____% of the Eligible Persons with eligible dependents, have enrolled for coverage.

STANDARD PREMIUM RATES

☐ Yes ☐ No

	For Internal Use Only - BlueStar Ben.Agree#: ____ ____ Health Coverage:	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ PPO/Indemnity Dental Coverage:	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ Vision Coverage:	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ ____ Coverage:	*For Internal Use Only - BlueStar Ben.Agree#:* ____ ____ ____ Coverage:	Total
1. Employee only:	$	$	$	$	$	$
2. Employee plus one dependent:	$	$	$	$	$	$
3. Employee plus two or more dependents:	$	$	$	$	$	$
4. Spouse:	$	$	$	$	$	$
5. Child(ren):	$	$	$	$	$	$
6. Family:	$	$	$	$	$	$
7. Other:	$	$	$	$	$	$
Single Tier Rate structure - Complete item 1						
Two Tier Rate structure - Complete items 1 and 6						
Three Tier Rate structure - Complete items 1, 2, and 3						
Four Tier Rate Structure - Complete items 1, 4, 5, and 6						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$	$	$	$	$	$
Family Coverage:	$	$	$	$	$	$

MINIMUM PREMIUM PROGRAM

☐ Yes ☐ No

Monthly Minimum Premium: ☐ Rate per Employee **or** ☐ Single and Family Rates

Health Coverage: $_____ Dental Coverage: $_____

Monthly CAP (Claims as Paid) Maximum: ☐ Rate per Employee **or** ☐ Single and Family Rates

Health Coverage: $_____ Dental Coverage: $_____

Individual Pooling Limit per Covered Person: $_____

Terminal Liability Payment: $_____; ☐ Rate per Employee **or** ☐ Single and Family Rates

Terminal Administrative Fee: $_____; ☐ Rate per Employee **or** ☐ Single and Family Rates **or** ☐ N/A

Rates are based on an enrollment of: _____Single Coverage Units and _____ Family Coverage Units

COST - PLUS PROGRAM

☒ **Yes** ☐ **No**

Service Charges:

☒ _____% of Net Claim Payments **or** $59.02 per employee per month
☒ Applies to all coverage(s)
☒ Different percentage(s) or amount(s) for the following types of coverage(s). Please specify below:

For HMO Coverage: _____% of _____ Claim Payments **or** $_____per employee per month
For _____ Coverage: _____% of _____ Claim Payments **or** $_____per employee per month
Other (please specify): Service fees $154.55 for single coverage and $467.88 for family coverage per month

Blue Care Connection® ("BCC"):

BCC Program (may select one):
☒ Blue Care Advisor
☐ Please refer to Additional Provisions

☐ Fee: $_____ per covered employee per month for administration of the program.
☒ Fee is included in the Service Charges.

Blue Care Custom

☐ Health Dialog **(may select one)** Health Dialog Fee: **$**_____ per covered employee per month
- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

☐ American Healthways **(may select one)**
- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month:

Conditions:	*Package A - Fees*	*Package B - Fees*	*Package C - Fees*
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

Payment Method: ☐ Transfer Payment ☒ Post Payment

If Transfer Payment, Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer
☐ Other (please specify): _____

Payment Period: ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly
☐ Other (please specify): _____

Claim Settlement: ☒ Monthly ☐ Quarterly ☐ Other (please specify): _____

If Transfer Payment, Tentative Final Settlement Period:
Transfer Payments to be made for the following time period after termination:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

The Effective Date of Termination for a person who ceases to meet the definition of Eligible Person:

☐ The date such person ceases to meet the definition of Eligible Person.

☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.

☐ Other:______.

Prescription Drug Rebate: $14.03 per covered employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

APPLICABLE TO MINIMUM PREMIUM ("MPP") AND COST-PLUS PROGRAMS ONLY: **PLAN PROVIDER ACCESS FEE(S):** ☒ **Yes** ☐ **No**
Group Number(s): P06652 PPO,P06870 HSA,P07366 HSA
☒ % of ADP Savings: 2.8%
☐ $ Per Employee per month (For MPP, this amount also included in Monthly Minimum Premium): $_____
Please complete for groups with multiple products (for example, Comprehensive Major Medical and PPO) with separate access fees: **Group Number(s):** _____
☐% of ADP Savings: _____%
☐ $ Per Employee per month (For MPP, this amount also included in Monthly Minimum Premium): $_____

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this Benefit Program Application ("BPA") and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS:

(a) Reimbursement Provision: ☒ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery (under cost-plus funding) or deduct 25% of the net recovery from the amount credited to the group's experience (under premium funding) after attorneys' fees, if any, have been paid.

(b) Certificate of Creditable Coverage: ☒ Yes ☐ No

If yes: It is understood and agreed that HCSC will issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Policy and information provided to HCSC by the Employer.

If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Policy.

(c) BlueCare® Dental HMO Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(d) Fort Dearborn Life Insurance purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(e) Excess Loss Coverage purchased: ☒ Yes ☐ No *(If yes, complete separate application.)*

(f) Case Management: ☒ Yes ☐ No

If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

(g) Electronic Issuance: The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet, or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

(h) Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

ADDITIONAL PROVISIONS: State mandates apply, rx copay effective 10/1/09 applies

☐ Additional Provisions are specified in the Exhibit attached hereto and made a part of this BPA.

Sherri Mensavage
Sales Representative

890
District

Mike Wojcik
Producer Representative

The Horton Group
Producer Firm

10320 Orland Parkway, Orland Park, IL 60467
Producer Address

36-3672171
Producer Tax I.D. No.

R. E. C.
Signature of Authorized Purchaser

Village Manager
Title

11/5/09
Date

Witness

$_____ Amount Submitted

UNDERWRITING USE ONLY

Date BPA approved:
Signature of Underwriter

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No.: 206338 By: Paul G. Grimes
Print Signer's Name Here

➡ [signature]
Signature and Title

Group Name: Village of Orland Park

Address: 14700 Ravinia Avenue

City: Orland Park State: IL Zip Code: 60462

Dated this 5th day of Nov 2009
Month Year

BlueCross BlueShield
of Illinois

APPLICATION FOR EXCESS LOSS COVERAGE
(HMO Cost-Plus Accounts Only)

Customer Number: 206338
Employer Group Name: Village of Orland Park
Employer Group Address: 14700 Ravinia Avenue
Orland Park IL 60462
Employer Group Number(s): H06652
Effective Date of Policy: 01/01/2010

Is this a Unified group (HMO Excess Loss Coverage and Indemnity Excess Loss Coverage)?

☒ Yes ☐ No

If yes, complete separate HMO and Indemnity Excess Loss Coverage Applications.

Aggregate Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 8 below.

1. Excess Loss Coverage Period:

   From 01/01/2010 to 12/31/2010

2. Aggregate Excess Loss Coverage shall apply to:

   ☐ HMO Claims (not including fixed amounts paid to Participating IPAs)

   ☒ HMO claims and outpatient drug claims

3. Average Claim Value: $5,161.68 (per employee).

4. Attachment Point: 125% of the Average Claim Value.

5. Aggregate Excess Loss Limit Claim Value: $6,452.04
   (equals the Average Claim Value multiplied by the Attachment Point)

6. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $574,876.76, as specified in Section III of the Policy.

7. Excess Loss Premium

   ☐ Monthly: $ each month

   ☒ Annual (Due on the Effective Date of Policy): $8,113.00

8. The premium is based upon a current membership of 38 Individual Coverage Units and 61 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 5 below.

1. Excess Loss Coverage Period:

   From 01/01/2010 to 12/31/2010

2. Individual Excess Loss Coverage shall apply to:

   ☐ HMO Claims (not including fixed amounts paid to Participating IPAs)

   ☒ HMO claims and outpatient prescription drugs

3. Individual Excess Loss Coverage Limit: $100,000 per Covered Person during the Excess Loss Coverage Period

4. Excess Loss Premium (select one):

   ☒ Monthly: $ each month **or** $21.91 per Enrollee each month

   ☐ Annual (Due on the Effective Date of Policy): $

5. The premium is based upon a current membership of 38 Individual Coverage Units and 61 Family Coverage Units.

Additional Provisions:

12 month renewal. State Mandates apply. Rx changes to copays effective 10/1/2009.

The undersigned person represents that he/she is authorized and responsible for purchasing excess loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Excess Loss Coverage Policy into which this Application for Excess Loss Coverage shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). Upon acceptance, HCSC shall issue an Excess Loss Coverage Policy to the Employer Group. Upon acceptance of this Application and issuance of the Excess Loss Coverage Policy, the Employer Group shall be referred to as "The Policyholder."

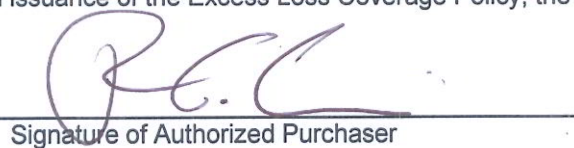
Sherri Mensavage

Sales Representative

Carl Charvat

Printed Name of Underwriter

Signature of Underwriter



Signature of Authorized Purchaser

Village Manager

Title of Authorized Purchaser

11/5/09

Date

BlueCross BlueShield of Illinois

APPLICATION FOR EXCESS LOSS COVERAGE
(Cost-Plus Accounts Only)

Employer Group Name: Village of Orland Park
Employer Group Address: 14700 Ravinia Avenue
Orland Park, Illinois 60462
Account Number: 206338
Employer Group Number(s): H S A P07366, P06870
Effective Date of Policy: 01/01/2010

Is this a Unified group (Indemnity Excess Loss Coverage and HMO Excess Loss Coverage)? ☒ Yes ☐ No
If yes, please complete separate Indemnity and HMO Excess Loss Coverage Applications.

Aggregate Excess Loss Coverage: ☒ Yes ☐ No
If yes, complete items 1 through 9 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Excess Loss Coverage Period:

   ☐ New Coverage (Select one from below):

   ☐ Standard: Claims incurred and paid from: _____ to _____

   ☐ "Run-in" included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____

   ☒ Renewal of Existing Coverage:

   Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010
3. Aggregate Excess Loss Coverage shall apply to:

   ☒ Medical Claims ☐ Vision Claims

   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)

   ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims

   ☐ Other (please specify): _____
4. Average Claim Value: $9,208.92 (per employee).

   ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee
5. Attachment Point: 125% of the Average Claim Value.
6. Aggregate Excess Loss Limit Claim Value: $11,511.12

(equals the Average Claim Value multiplied by the Attachment Point)

7. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $145,040.11 as specified in Section III of the Policy.

8. Annual Premium

   (Due on the Effective Date of Policy): $1,505.00

9. The annual premium is based upon a current membership of 2 Individual Coverage Units and 12 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Excess Loss Coverage Period:

   ☐ New Coverage (Select one from below):

   ☐ Standard: Claims incurred and paid from: _____ to: _____

   ☐ "Run-in"included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____

   ☒ Renewal of Existing Coverage:

   I Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010.

3. Individual Excess Loss Coverage shall apply to:

   ☒ Medical Claims ☐ Vision Claims

   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)

   ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims

   ☐ Other (please specify): _____

4. Individual Excess Loss Coverage Limit: $100,000

   ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee

5. Premium (select one):

   ☒ Monthly: $_____ each month **or** $76.71 per employee each month.

   ☐ Annual: $_____

6. The premium is based upon a current membership of 2 Individual Coverage Units and 12 Family Coverage Units.

Additional Provisions:

12 month renewal period. All state mandates apply. RX copay tier changed 10/1/09 is included.

The undersigned person represents that he/she is authorized and responsible for purchasing excess loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Excess Loss Coverage Policy into which this Application for Excess Loss Coverage shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). Upon acceptance, HCSC shall issue a Excess Loss Coverage

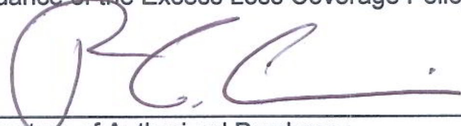
Policy to the Employer Group. Upon acceptance of this Application and issuance of the Excess Loss Coverage Policy, the Employer Group shall be referred to as the "The Policyholder."

Sherri Mensavage

Sales Representative

Carl Charvat

Name of Underwriter



Signature of Authorized Purchaser

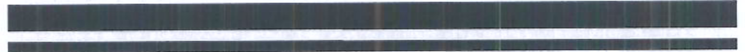
Village Manager

Title of Authorized Purchaser

11/5/09

Date

	UNDERWRITING AUTHORIZATION
INTERNAL USE ONLY	Date Application approved by Underwriting: ____________
	Signature of Underwriter: ____________



APPLICATION FOR EXCESS LOSS COVERAGE
(Cost-Plus Accounts Only)

Employer Group Name: Village of Orland Park
Employer Group Address: 14700 Ravinia Avenue
Orland Park, Illinois 60462
Account Number: 206338
Employer Group Number(s): PPO P06652
Effective Date of Policy: 01/01/2010

Is this a Unified group (Indemnity Excess Loss Coverage and HMO Excess Loss Coverage)? ☒ Yes ☐ No
If yes, please complete separate Indemnity and HMO Excess Loss Coverage Applications.

Aggregate Excess Loss Coverage: ☒ Yes ☐ No
If yes, complete items 1 through 9 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Excess Loss Coverage Period:

   ☐ New Coverage (Select one from below):

   ☐ Standard: Claims incurred and paid from: _____ to _____

   ☐ "Run-in" included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____

   ☒ Renewal of Existing Coverage:

   Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010
3. Aggregate Excess Loss Coverage shall apply to:

   ☒ Medical Claims ☐ Vision Claims

   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)

   ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims

   ☐ Other (please specify): _____
4. Average Claim Value: $14,845.44 (per employee).

   ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee
5. Attachment Point: 125% of the Average Claim Value.
6. Aggregate Excess Loss Limit Claim Value: $18,556.80

(equals the Average Claim Value multiplied by the Attachment Point)

7. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $3,490,534.00 as specified in Section III of the Policy.

8. Annual Premium

   (Due on the Effective Date of Policy): $49,899

9. The annual premium is based upon a current membership of 123 Individual Coverage Units and 86 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Excess Loss Coverage Period:

   ☐ New Coverage (Select one from below):

   ☐ Standard: Claims incurred and paid from: _____ to: _____

   ☐ "Run-in"included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____

   ☒ Renewal of Existing Coverage:

   l Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010.

3. Individual Excess Loss Coverage shall apply to:

   ☒ Medical Claims ☐ Vision Claims

   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)

   ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims

   ☐ Other (please specify): _____

4. Individual Excess Loss Coverage Limit: $100,000

   ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee

5. Premium (select one):

   ☒ Monthly: $_____ each month **or** $76.71 per employee each month.

   ☐ Annual: $_____

6. The premium is based upon a current membership of 123 Individual Coverage Units and 86 Family Coverage Units.

Additional Provisions:

12 month renewal period. All applicate state mandates apply. RX copay tier changed 10/1/09 is included.

The undersigned person represents that he/she is authorized and responsible for purchasing excess loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Excess Loss Coverage Policy into which this Application for Excess Loss Coverage shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). Upon acceptance, HCSC shall issue a Excess Loss Coverage

Policy to the Employer Group. Upon acceptance of this Application and issuance of the Excess Loss Coverage Policy, the Employer Group shall be referred to as the "The Policyholder."

Sherri Mensavage

Sales Representative

Carl Charvat

Name of Underwriter

Signature of Authorized Purchaser

Village Manager

Title of Authorized Purchaser

Date

	UNDERWRITING AUTHORIZATION
INTERNAL USE ONLY	Date Application approved by Underwriting: ______________________
	Signature of Underwriter: ______________________

Delta Dental PPO

Administrative Services Contract

Village of Orland Park

Group #8331
Effective Date: ~~10/01/08~~ 1/1/2010

Delta Dental of Illinois

ADMINISTRATIVE SERVICE AGREEMENT

AGREEMENT entered into as of this 1st day of October, 2007, by and between Delta Dental of Illinois ("DDIL") and Village of Orland Park.

WHEREAS, DDIL is a not-for-profit dental service plan corporation organized under the laws of the State of Illinois for the purpose of establishing and operating dental service plans; and

WHEREAS, Village of Orland Park wishes to provide a Group Dental Program for its eligible employees and their dependents; and

WHEREAS, Village of Orland Park wishes to fully underwrite the risk of its Group Dental Plan, accept liability for payment of benefits to eligible employees and their dependents, and to formulate policy regarding the processing and payment of claims under this Group Dental Plan; and

WHEREAS, DDIL is willing to perform the administrative services hereinafter set forth with respect to the dental benefits for which Village of Orland Park will be obligated.

NOW, THEREFORE, in consideration of the mutual covenants expressed herein and payments to be made as hereinafter provided, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, DDIL and Village of Orland Park hereby mutually agree to the following:

ARTICLE I. DENTAL PROGRAM

1.1 Funding of Program: As of October 1, 2007, Village of Orland Park shall self-fund a dental care program for its employees and their dependents. The terms, conditions and benefits of this program are set forth in the prototype Group Dental Plan, a copy of which is attached hereto and marked as Exhibit A and hereby made a part of this Agreement as fully recited over the signatures hereto affixed. Village of Orland Park shall completely underwrite the risk under this Group Dental Plan and assume all liability with respect to the payment of claims by covered employees and covered dependents for covered dental benefits.

1.2 Appointment of DDIL: Village of Orland Park hereby appoints DDIL to administer the processing and payment of claims as more fully set forth in Article 3. In accepting this appointment, DDIL assumes no obligation whatsoever of underwriting any portion of this risk.

1.3 Named Fiduciary: Village of Orland Park shall be the fiduciary for purposes of this Group Dental Plan. As such, Village of Orland Park shall have the right, in its sole discretion, to review all claim decisions under this Group Dental Plan, including decisions on review, and to overrule any decision made by DDIL under Article 3.1. Village of Orland Park's decision shall be final. Village of Orland Park acknowledges and agrees that DDIL is not a fiduciary with respect to the Group Dental Plan or any claims submitted hereunder, and that the duties of DDIL concerning claims processing under the Group Dental Plan are limited to application of the rules determining eligibility for benefits contained in this Group Dental Plan and the claim payment guidelines which are prescribed or approved by Village of Orland Park in its sole discretion.

1.4 Funding Arrangement: Village of Orland Park agrees to establish a pre-fund of $15,464.00 for the use of DDIL as Administrator of this Group Dental Plan. DDIL shall furnish Village of Orland Park monthly accountings showing the amount of claims paid during the preceding month. Within ten (10) days of the date of said accounting, Village of Orland Park shall pay DDIL the amount shown on this monthly accounting as the full amount of claims paid. DDIL may render interim accountings at any time if the pre-fund becomes depleted so that it has insufficient funds to pay claims. DDIL shall in no event be obligated to pay claims except from funds provided by Village of Orland Park.

1.5 Administrative Fees: Village of Orland Park agrees to pay DDIL, as Administrator of this Group Dental Plan, $3.71 per employee per month, which amount represents the administrative fee for processing dental claims under this Group Dental Plan. DDIL will bill Village of Orland Park monthly for its fees in administering this program during the previous month. Said amount is due and payable to DDIL within ten

(10) days of the date of the monthly invoice. DDIL will bill Village of Orland Park for all those enrolled employees whose coverage is in effect on and prior to the 15th of the month; for employees enrolled after the 15th of the month, DDIL will not bill Village of Orland Park until the first of the following month. For employees who terminate coverage after the 15th of the month, DDIL will bill Village of Orland Park the applicable administrative fee for the entire month. For employees who terminate coverage on or prior to the 15th of the month, DDIL will not bill Village of Orland Park the applicable administrative fee for that month. At the end of the period beginning October 1, 2008 and ending December 31, 2011, DDIL will re-evaluate the administrative fees and advise Village of Orland Park of any adjustments to this fee arrangement.

1.6 Provider Service Fee: DDIL has written agreements with its Participating Dentists and its Preferred Provider Dentists authorizing the deduction of two percent (2%) from benefit payments made to them. The provider service fee shall be returned by DDIL and applied to a capital fund for administrative risk factors and provider services. The amount deducted from benefit payments shall not result in an increase in the Dentists' charges to covered individuals. The monthly accounting DDIL provides Village of Orland Park of the amount of claims paid during the preceding month, pursuant to Article 1.4, shall include the provider service fee.

1.7 Tax or Assessment: In the event that any governmental unit shall impose any new tax or assessment not now in effect, which is measured directly by the payments made to DDIL by Village of Orland Park or in the event that the rate of any such tax or assessment now in effect should hereafter be increased, the Administrative Fee, pursuant to Article 1.5, shall be increased by the amount of such new tax or assessment.

ARTICLE II. OBLIGATIONS OF EMPLOYER

2.1 Eligibility: Village of Orland Park has the authority to formulate terms of eligibility under this Group Dental Plan and all such determinations shall be made exclusively by it. Village of Orland Park shall compile and furnish to DDIL on or prior to the first day of every month, commencing on the Group Plan Commencement Date, a list of all Eligible Employees, showing their social security numbers, the dates of hire, and if applicable, the location code. DDIL shall not be obligated to make payment for benefits to any employee or his/her dependents unless the employee (and the dependents) is(are) included on the list of Eligible Employees submitted as set forth in this Agreement (or any revision or correction of such list).

2.2 Claim Guidelines: Village of Orland Park has power to formulate policy regarding claim guidelines. Guidelines for the handling of claims made in accordance with this program are attached hereto and made a part of this Agreement. Village of Orland Park has approved said guidelines and may, in its sole discretion, replace or modify such guidelines upon thirty (30) days' advance written notice to DDIL.

2.3 Review of Claim Determinations: Village of Orland Park has the right to review and override all claim determinations whether said claims are approved or denied. If Village of Orland Park overrides a claim determination, it shall notify DDIL in writing of its decision to do so. In the event that this Group Dental Plan has been terminated and Village of Orland Park wishes to override any previous claim decision made by DDIL, then Village of Orland Park shall be responsible for the payment of said disputed claim.

2.4 Summary Plan Description: DDIL will provide Village of Orland Park with a model Summary Plan Description of the benefits and services provided under this Group Dental Plan. It is Village of Orland Park's responsibility to adapt this Summary Plan Description for its use and to distribute said Summary Plan Description to each Employee.

ARTICLE III. OBLIGATIONS OF DDIL

3.1 Claims Processing: Subject to Articles 2.3 and 4.2, DDIL shall be responsible for determining whether a claim submitted under the Group Dental Plan is eligible for payment and paying any and all claims filed pursuant to the terms, conditions and benefits thereunder.

3.2 Non-Assignment of Benefits: A Covered Individual's claim for Dental Benefits under this Contract is expressly non-assignable and non-transferable in whole or in part to any person or entity including

any Dentist at any time. DDIL shall make benefit payments for services rendered by a Dentist who participates in a Delta Dental network directly to that Dentist and the right to receive that payment shall not be assignable or transferable. DDIL shall make benefit payments for services rendered by a Dentist who does not participate in a Delta Dental network directly to the Subscriber and the right to receive such payment shall not be assignable or transferable.

3.3 Claim Records: DDIL shall maintain on a current basis complete records of its administration of claims processed under this Agreement.

3.4 Reports: DDIL agrees to furnish Village of Orland Park with monthly reports indicating the amount of claims which have been paid during the previous month.

3.5 Directories: DDIL shall furnish to Village of Orland Park on the Group Plan Commencement Date and at reasonable times thereafter a directory of Participating Dentists who have agreed to render the services described in this Agreement. By issuing this directory, DDIL does not guarantee the availability of any particular Dentist.

ARTICLE IV. TERMINATION

4.1 Notice of Termination: DDIL or Village of Orland Park may terminate this Agreement at any time by giving the other party sixty (60) days' prior written notice.

4.2 Claims Processing: At the end of this termination notice period, DDIL shall have no further obligation to administer benefits for claims that were submitted after the termination date for services performed before the termination date, unless the parties agree in writing to an alternate arrangement. The obligation to pay such claims shall remain the obligation of Village of Orland Park.

4.3 Final Accounting: DDIL shall render a final accounting to Village of Orland Park within thirty (30) days after DDIL ceases processing claims as provided herein.

4.4 Reserve Fund: The balance of the reserve fund established pursuant to Article 1.4 shall be returned to Village of Orland Park within fifteen (15) working days after DDIL renders a final accounting as provided in Article 4.3.

ARTICLE V. GENERAL PROVISIONS

5.1 Independent Contractors: Dentists providing services are independent contractors and neither Village of Orland Park nor DDIL shall be liable for any act or omission of any dentist, his or her employees or agents or any person furnishing dental or other professional services under this Group Dental Plan.

5.2 Dispute Resolution: The parties shall make a good faith effort to resolve any and all controversies or claims arising out of or relating to this Agreement, or breach thereof. Should such efforts prove unsuccessful, the aggrieved party shall provide thirty (30) days' written notice to the other party that it intends to seek resolution by arbitration. After said thirty (30) days, the controversy or claim shall be referred to and settled by arbitration and in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The determination of the Arbitrator(s) shall be final and binding upon the parties, and judgment upon the award rendered by the Arbitrator(s) may be entered in any court having jurisdiction thereof.

5.3 Entire Agreement: This Agreement constitutes the entire agreement between the parties and no oral representations or promises made or received prior to or during its negotiation shall modify or amend its terms. This Agreement includes all Exhibits attached hereto.

5.4 Amendment: This Agreement may be modified or amended by agreement between the parties. Any changes must be in writing and executed with the same formality as this Agreement.

5.5 Choice of Law: This Agreement shall be governed by and interpreted under the laws of the State of Illinois.

5.6 Severability: In the event that any provision of this Agreement shall be illegal or otherwise unenforceable, such provision shall be severed, and the entire Agreement shall not fail on account thereof and the balance of the Agreement shall continue in full force and effect.

5.7 Notices: All notices, demands or consents under this Agreement shall be in writing and be deemed served when delivered by certified mail, return receipt requested, addressed as follows:

If to Village of Orland Park:

Stephana Przybylski
Village of Orland Park
14700 Ravinia Avenue
Orland Park, Illinois 60462

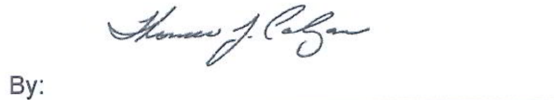
If to DDIL:

Thomas J. Colgan, President/CEO
Delta Dental of Illinois
801 Ogden Avenue
Lisle, Illinois 60532

or to such other address as the one party may furnish to the other from time to time by a notice as required hereunder.

The parties warrant that the officers who execute this Agreement on their behalf are authorized to perform this act.

DELTA DENTAL OF ILLINOIS



By:

Title: President/CEO

Date: October 1, 2009

VILLAGE OF ORLAND PARK

By:

Title: Village Manager

Date: 11/5/09

APPENDIX A
SCHEDULE OF DENTAL BENEFITS

This Group Dental Plan will pay for those dental services or procedures listed in this Schedule, subject to the exclusions, terms and conditions set forth in this Schedule. Benefit payments are subject to any applicable Deductibles, waiting periods and coverage limits listed in the Dental Plan Specifications.

The level of covered benefits paid under this Group Dental Plan depends on whether you go to a Delta Dental PPO Dentist, a Delta Dental Premier Dentist, or an Out-of-network Dentist. The following outlines the level of Dental Benefits paid.

IF YOU GO TO A DELTA DENTAL PPO DENTIST, this Group Dental Plan will pay the designated co-payment percentage, as set forth in this Schedule, of the fee that the Delta Dental PPO Dentist has agreed to accept as full reimbursement under this Group Dental Plan. Delta Dental PPO Dentists may only bill you the difference between the fee they have agreed to accept as full reimbursement for services rendered and this Group Dental Plan's benefit payment for a covered service.

IF YOU GO TO A DELTA DENTAL PREMIER DENTIST, this Group Dental Plan will pay the designated co-payment percentage, as set forth in this Schedule, of DDIL's Approved Fee. A Delta Dental Premier Dentist of DDIL is bound to accept DDIL's Approved Fee as full reimbursement for his/her services after this Group Dental Plan's benefit payment.

IF YOU GO TO AN OUT-OF-NETWORK DENTIST, this Group Dental Plan will pay the designated co-payment percentage, as set forth in this Schedule (except for Cast Restorations and Prosthodontic services), of DDIL's Approved Fee. This Group Dental Plan will pay up to the maximum allowance for Cast Restorations and Prosthodontic services as set forth in this Schedule. The Out-of-network Dentist may bill you the difference, if any, between his/her fee and this Group Dental Plan's benefit payment.

The benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for predetermination of contract benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating dentist and only relates to the level of payment which this Group Dental Plan is required to make.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage

COVERED DENTAL SERVICES

I. DIAGNOSTIC (D0100 - D0999)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	OUT-OF-NETWORK DENTIST
CLINICAL ORAL EVALUATIONS				
0120	Periodic oral evaluation: *twice per calendar year*	100%	100%	100%
0140	Limited oral evaluation - problem focused	100%	100%	100%
0150	Comprehensive oral evaluation: once per Dentist	100%	100%	100%
0160	Detailed and extensive oral evaluation - problem focused: once per Dentist	100%	100%	100%
0170	Re-evaluation - limited, problem focused	100%	100%	100%
0180	Comprehensive periodontal evaluation - new or established patient	100%	100%	100%
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)				
0210	Intra-oral - complete series (including bitewings): *once in a 36-month interval*	100%	100%	100%
0220	Intra-oral - periapical first film	100%	100%	100%
0230	Intra-oral - periapical each additional film	100%	100%	100%
0240	Intra-oral - occlusal film	100%	100%	100%
0270	Bitewing - single film	100%	100%	100%
0272	Bitewings - two films	100%	100%	100%
0274	Bitewings - four films	100%	100%	100%
0277	Vertical bitewings - 7 to 8 films: *once in a 36-month interval*	100%	100%	100%
0330	Panoramic film: once in a 36-month interval	100%	100%	100%
0340	Cephalometric film (with orthodontic coverage only)	100%	100%	100%
TESTS AND EXAMINATIONS				
0470	Diagnostic casts	100%	100%	100%

A full mouth x-ray includes bitewing x-rays; panoramic x-ray in conjunction with any other x-ray is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.

Bitewing x-rays other than vertical bitewings are limited to not more than two series per calendar year.

Diagnostic casts are a covered benefit only when rendered more than 30 days prior to definitive treatment.

II. PREVENTIVE (D1000 - D1999)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	OUT-OF-NETWORK DENTIST
DENTAL PROPHYLAXIS*				
1110	Prophylaxis - adult: twice per calendar year	100%	100%	100%
1120	Prophylaxis - child: twice per calendar year	100%	100%	100%

**With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for*

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage

topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)				
1203	Topical application of fluoride (prophylaxis not included) - child: *once per calendar year for dependent children under age 19*	100%	100%	100%
OTHER PREVENTIVE SERVICES				
1351	Sealant - per tooth	100%	100%	100%
SPACE MAINTENANCE (PASSIVE APPLIANCES)				
1510	Space maintainer - fixed - unilateral	100%	100%	100%
1515	Space maintainer - fixed - bilateral	100%	100%	100%
1520	Space maintainer - removable - unilateral	100%	100%	100%
1525	Space maintainer - removable - bilateral	100%	100%	100%
1550	Recementation of space maintainer	100%	100%	100%

Sealants are a covered Dental Benefit when applied once per tooth to first and second permanent molars which are free of caries and restorations; for dependent children under age 16.

Space maintainers are a covered Dental Benefit only if used as a "passive" appliance when necessary due to the premature loss of deciduous dentition, for dependent children under age 14.

IIIA. RESTORATIVE (D2000 - D2399)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
AMALGAM RESTORATIONS (INCLUDING POLISHING)				
2140	Amalgam - one surface, primary or permanent	100%	100%	100%
2150	Amalgam - two surfaces, primary or permanent	100%	100%	100%
2160	Amalgam - three surfaces, primary or permanent	100%	100%	100%
2161	Amalgam - four or more surfaces, primary or permanent	100%	100%	100%
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
2330	Resin-based composite -one surface, anterior	100%	100%	100%
2331	Resin-based composite - two surfaces, anterior	100%	100%	100%
2332	Resin-based composite - three surfaces, anterior	100%	100%	100%
2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	100%	100%	100%
2390	Resin-based composite crown, anterior	100%	100%	100%

Amalgam and resin restorations (fillings) are limited to once per surface in a 12-month interval.

When multiple restorations involving the proximal and occlusal/incisal surfaces are requested or performed on the same tooth, the level of benefits will be limited to that of one multi-surface restoration.

When a resin restoration is placed on a molar or pre-molar (except on the facial surface of a pre-molar), the level of benefits will be limited to that of an amalgam.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage

IIIB. RESTORATIVE (D2400 - D2999) (PERMANENT TEETH ONLY)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
INLAY/ONLAY RESTORATIONS				
2542	Onlay - metallic - two surfaces	80%	80%	$135.00
2543	Onlay - metallic - three surfaces	80%	80%	$135.00
2544	Onlay - metallic - four or more surfaces	80%	80%	$135.00
CROWNS - SINGLE RESTORATIONS ONLY				
2710	Crown - resin (indirect)	80%	80%	$194.00
2720	Crown - resin with high noble metal	80%	80%	$424.00
2721	Crown - resin with predominantly base metal	80%	80%	$344.00
2722	Crown - resin with noble metal	80%	80%	$344.00
2740	Crown - porcelain/ceramic substrate	80%	80%	$387.00
2750	Crown - porcelain fused to high noble metal	80%	80%	$424.00
2751	Crown - porcelain fused to predominantly base metal	80%	80%	$401.00
2752	Crown - porcelain fused to noble metal	80%	80%	$378.00
2780	Crown - 3/4 cast high noble metal	80%	80%	$427.00
2781	Crown - 3/4 cast predominantly base metal	80%	80%	$427.00
2782	Crown - 3/4 cast noble metal	80%	80%	$427.00
2790	Crown - full cast high noble metal	80%	80%	$424.00
2791	Crown - full cast predominantly base metal	80%	80%	$378.00
2792	Crown - full cast noble metal	80%	80%	$378.00
OTHER RESTORATIVE SERVICES				
2910	Recement inlay	80%	80%	$ 33.00
2920	Recement crown	80%	80%	$ 33.00
2930	Prefabricated stainless steel crown - primary tooth	80%	80%	$119.00
2931	Prefabricated stainless steel crown - permanent tooth	80%	80%	$132.00
2940	Sedative filling	80%	80%	$ 42.00
2950	Core build-up, including any pins	80%	80%	$ 94.00
2951	Pin retention - per tooth, in addition to restoration	80%	80%	$ 19.00
2952	Cast post and core in addition to crown	80%	80%	$167.00
2954	Prefabricated post and core in addition to crown	80%	80%	$132.00

When a cast restoration with a cosmetic component is requested or performed on a molar other than an upper first molar, the level of benefits will be limited to that of a cast metal restoration.

When the retentive quality of a tooth does not qualify for a cast restoration (radiographic evidence of decay or missing tooth structure on less than four surfaces), the level of benefits will be limited to that of an amalgam or resin restoration.

When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam.

When a porcelain/ceramic onlay is requested or placed, the level of benefits will be limited to that of a cast metal onlay.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage

IV. ENDODONTICS (D3000 - D3999)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
PULPOTOMY				
3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament: *primary teeth*	100%	100%	100%
3221	Gross pulpal debridement, primary and permanent teeth	100%	100%	100%
ENDODONTIC THERAPY ON PRIMARY TEETH				
3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	100%	100%	100%
3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	100%	100%	100%
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)				
3310	Anterior (excluding final restoration)	100%	100%	100%
3320	Bicuspid (excluding final restoration)	100%	100%	100%
3330	Molar (excluding final restoration)	100%	100%	100%
3332	Incomplete endodontic therapy; inoperable or fractured tooth	100%	100%	100%
3333	Internal root repair of perforation defects	100%	100%	100%
ENDODONTIC RETREATMENT				
3346	Retreatment of previous root canal therapy - anterior	100%	100%	100%
3347	Retreatment of previous root canal therapy - bicuspid	100%	100%	100%
3348	Retreatment of previous root canal therapy - molar	100%	100%	100%
APEXIFICATION/RECALCIFICATION PROCEDURES				
3351	Apexification/recalcification - initial visit	100%	100%	100%
3352	Apexification/recalcification - interim medication replacement	100%	100%	100%
3353	Apexification/recalcification - final visit	100%	100%	100%
APICOECTOMY/PERIRADICULAR SERVICES				
3410	Apicoectomy/periradicular surgery - anterior	100%	100%	100%
3421	Apicoectomy/periradicular surgery - bicuspid (first root)	100%	100%	100%
3425	Apicoectomy/periradicular surgery - molar (first root)	100%	100%	100%
3426	Apicoectomy/periradicular surgery (each additional root)	100%	100%	100%
3430	Retrograde filling - per root	100%	100%	100%
3450	Root amputation - per root	100%	100%	100%
OTHER ENDODONTIC PROCEDURES				
3920	Hemisection (including any root removal), not including root canal therapy	100%	100%	100%

Endodontics includes pulpal and root canal therapy.

When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage

Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit.

V. PERIODONTICS (D4000 - D4999)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	OUT-OF-NETWORK DENTIST
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)				
4210	Gingivectomy or gingivoplasty - per quadrant	100%	100%	100%
4211	Gingivectomy or gingivoplasty - per tooth	100%	100%	100%
4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	100%	100%	100%
4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	100%	100%	100%
4245	Apically positioned flap	100%	100%	100%
4249	Clinical crown lengthening - hard tissue	100%	100%	100%
4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	100%	100%	100%
4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	100%	100%	100%
4263	Bone replacement graft - first site in quadrant	100%	100%	100%
4264	Bone replacement graft - each additional site in quadrant	100%	100%	100%
4270	Pedicle soft tissue graft procedure	100%	100%	100%
4271	Free soft tissue graft procedure (including donor site surgery)	100%	100%	100%
4273	Subepithelial connective tissue graft procedures	100%	100%	100%
4275	Soft tissue allograft	100%	100%	100%
4276	Combined connective tissue and double pedicle graft	100%	100%	100%
NON-SURGICAL PERIODONTAL SERVICE				
4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	100%	100%	100%
4342	Periodontal scaling and root planing - one to three teeth, per quadrant	100%	100%	100%
4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	100%	100%	100%
OTHER PERIODONTAL SERVICES				
4910	Periodontal maintenance: *following active therapy, twice per calendar year**	100%	100%	100%

Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.

Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.

**With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage

**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

VI. PROSTHODONTICS (REMOVABLE) (D5000 - D5899)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)				
5110	Complete denture - maxillary	80%	80%	$578.00
5120	Complete denture - mandibular	80%	80%	$567.00
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)				
5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	80%	80%	$666.00
5212	Mandibular partial denture - acrylic base with clasps/rests	80%	80%	$542.00
5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	80%	80%	$666.00
5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	80%	80%	$690.00
5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	80%	80%	$512.00
ADJUSTMENTS TO DENTURES				
5410	Adjust complete denture -maxillary	80%	80%	$ 21.00
5411	Adjust complete denture -mandibular	80%	80%	$ 21.00
5421	Adjust partial denture -maxillary	80%	80%	$ 26.00
5422	Adjust partial denture -mandibular	80%	80%	$ 26.00
REPAIRS TO COMPLETE DENTURES				
5510	Repair broken complete denture base	80%	80%	$ 48.00
5520	Replace missing or broken teeth - complete denture (each tooth)	80%	80%	$ 40.00
REPAIRS TO PARTIAL DENTURES				
5610	Repair resin denture base	80%	80%	$ 64.00
5620	Repair cast framework	80%	80%	$ 79.00
5630	Repair or replace broken clasp	80%	80%	$ 74.00
5640	Replace broken teeth - per tooth	80%	80%	$ 54.00
5650	Add tooth to existing partial denture	80%	80%	$ 99.00
5660	Add clasp to existing partial denture	80%	80%	$114.00
5670	Replace all teeth and acrylic on cast metal framework (maxillary)	80%	80%	$ 99.00
5671	Replace all teeth and acrylic on cast metal framework (mandibular)	80%	80%	$ 99.00

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
DENTURE REBASE				
5710	Rebase complete maxillary denture	80%	80%	$200.00
5711	Rebase complete mandibular denture	80%	80%	$200.00
5720	Rebase maxillary partial denture	80%	80%	$189.00
5721	Rebase mandibular partial denture	80%	80%	$189.00
DENTURE RELINE PROCEDURES				
5730	Reline complete maxillary denture (chairside)	80%	80%	$109.00
5731	Reline complete mandibular denture (chairside)	80%	80%	$109.00
5740	Reline maxillary partial denture (chairside)	80%	80%	$101.00
5741	Reline mandibular partial denture (chairside)	80%	80%	$101.00
5750	Reline complete maxillary denture (laboratory)	80%	80%	$157.00
5751	Reline complete mandibular denture (laboratory)	80%	80%	$157.00
5760	Reline maxillary partial denture (laboratory)	80%	80%	$154.00
5761	Reline mandibular partial denture (laboratory)	80%	80%	$154.00

IX. PROSTHODONTICS, FIXED (D6200 - D6999)

(each retainer and each pontic constitutes a unit in a fixed partial denture)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
FIXED PARTIAL DENTURE PONTICS				
6210	Pontic - cast high noble metal	80%	80%	$428.00
6211	Pontic - cast predominantly base metal	80%	80%	$357.00
6212	Pontic - cast noble metal	80%	80%	$357.00
6240	Pontic - porcelain fused to high noble metal	80%	80%	$428.00
6241	Pontic - porcelain fused to predominantly base metal	80%	80%	$380.00
6242	Pontic - porcelain fused to noble metal	80%	80%	$380.00
6250	Pontic - resin with high noble metal	80%	80%	$376.00
6251	Pontic - resin with predominantly base metal	80%	80%	$302.00
6252	Pontic - resin with noble metal	80%	80%	$428.00
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS				
6545	Retainer -- cast metal for resin bonded fixed prosthesis	80%	80%	$286.00
6602	Inlay - cast high noble metal, two surfaces	80%	80%	$377.00
6603	Inlay - cast high noble metal, three or more surfaces	80%	80%	$311.00
6604	Inlay - cast predominantly base metal, two surfaces	80%	80%	$377.00
6605	Inlay - cast predominantly base metal, three or more surfaces	80%	80%	$311.00
6606	Inlay - cast noble metal, two surfaces	80%	80%	$377.00
6607	Inlay - cast noble metal, three or more surfaces	80%	80%	$311.00
6610	Onlay - cast high noble metal, two surfaces	80%	80%	$307.00
6611	Onlay - cast high noble metal, three or more surfaces	80%	80%	$307.00
6612	Onlay - cast predominantly base metal, two surfaces	80%	80%	$307.00
6613	Onlay - cast predominantly base metal, three or more surfaces	80%	80%	$307.00
6614	Onlay - cast noble metal, two surfaces	80%	80%	$307.00
6615	Onlay - cast noble metal, three or more surfaces	80%	80%	$307.00

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
FIXED PARTIAL DENTURE RETAINERS – CROWNS				
6720	Crown - resin with high noble metal	80%	80%	$424.00
6721	Crown - resin with predominantly base metal	80%	80%	$347.00
6722	Crown - resin with noble metal	80%	80%	$366.00
6750	Crown - porcelain fused to high noble metal	80%	80%	$442.00
6751	Crown - porcelain fused to predominantly base metal	80%	80%	$401.00
6752	Crown - porcelain fused to noble metal	80%	80%	$380.00
6780	Crown - 3/4 cast high noble metal	80%	80%	$428.00
6781	Crown - 3/4 cast predominantly base metal	80%	80%	$428.00
6782	Crown - 3/4 cast noble metal	80%	80%	$428.00
6790	Crown - full cast high noble metal	80%	80%	$428.00
6791	Crown - full cast predominantly base metal	80%	80%	$378.00
6792	Crown - full cast noble metal	80%	80%	$378.00
OTHER FIXED PARTIAL DENTURE SERVICES				
6930	Recement fixed partial denture	80%	80%	$ 48.00
6970	Cast post and core in addition to fixed partial denture retainer	80%	80%	$224.00
6971	Cast post and core as part of fixed partial denture retainer	80%	80%	$174.00
6972	Prefabricated post and core in addition to fixed partial denture retainer	80%	80%	$139.00
6973	Core build up for retainer, including any pins	80%	80%	$ 94.00

Prosthodontics includes cast restorations, fixed partial dentures, removable partial dentures, complete dentures, denture service and repair. Reline or rebase of an existing appliance is covered once in a 24-month interval.

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a covered benefit.

When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

When a porcelain/ceramic inlay or onlay is requested or placed, the level of benefits will be limited to that of a cast metal inlay or onlay.

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
	X. ORAL SURGERY D7000 - D7999)			
	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)			
7111	Coronal remnants - deciduous tooth	100%	100%	100%
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	100%	100%	100%
	SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)			
7210	Surgical removal of erupted tooth	100%	100%	100%
7220	Removal of impacted tooth - soft tissue	100%	100%	100%
7230	Removal of impacted tooth - partially bony	100%	100%	100%
7240	Removal of impacted tooth - completely bony	100%	100%	100%
7241	Removal of impacted tooth - completely bony with unusual surgical complications	100%	100%	100%
7250	Surgical removal of residual tooth roots (cutting procedure)	100%	100%	100%
	OTHER SURGICAL PROCEDURES			
7260	Oroantral fistula closure	100%	100%	100%
7261	Primary closure of a sinus perforation	100%	100%	100%
7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	100%	100%	100%
7280	Surgical access of an unerupted tooth	100%	100%	100%
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	100%	100%	100%
7282	Mobilization of erupted or malpositioned tooth to aid eruption	100%	100%	100%
7285	Biopsy of oral tissue - hard (bone, tooth)	100%	100%	100%
7286	Biopsy of oral tissue - soft (all others)	100%	100%	100%
7290	Surgical repositioning of teeth	100%	100%	100%
7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	100%	100%	100%
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES			
7310	Alveoloplasty in conjunction with extractions -per quadrant	100%	100%	100%
7320	Alveoloplasty not in conjunction with extractions -per quadrant	100%	100%	100%
	VESTIBULOPLASTY			
7350	Vestibuloplasty - ridge extension	100%	100%	100%
	SURGICAL EXCISION OF SOFT TISSUE LESIONS			
7410	Excision of benign lesion up to 1.25 cm	100%	100%	100%
7411	Excision of benign lesion greater than 1.25 cm	100%	100%	100%
7412	Excision of benign lesion, complicated	100%	100%	100%
7413	Excision of malignant lesion up to 1.25 cm	100%	100%	100%
7414	Excision of malignant lesion greater than 1.25 cm	100%	100%	100%
7415	Excision of malignant lesion, complicated	100%	100%	100%
7465	Destruction of lesion(s) by physical or chemical method, by report	100%	100%	100%

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
7440	Excision of malignant tumor - lesion diameter up to I.25 cm	100%	100%	100%
7441	Excision of malignant tumor - lesion diameter greater than I.25 cm	100%	100%	100%
7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to I.25 cm	100%	100%	100%
7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than I.25 cm	100%	100%	100%
7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	100%	100%	100%
7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than I.25 cm	100%	100%	100%
EXCISION OF BONE TISSUE				
7471	Removal of exostosis - per site	100%	100%	100%
7472	Removal of torus palatinus	100%	100%	100%
7473	Removal of torus mandibularis	100%	100%	100%
7485	Surgical reduction of osseous tuberosity	100%	100%	100%
SURGICAL INCISION				
7510	Incision and drainage of abscess - intraoral soft tissue	100%	100%	100%
OTHER REPAIR PROCEDURES				
7960	Frenulectomy (frenectomy or frenotomy) -separate procedure	100%	100%	100%
7970	Excision of hyperplastic tissue - per arch	100%	100%	100%
7971	Excision of pericoronal gingiva	100%	100%	100%
7972	Surgical reduction of fibrous tuberosity	100%	100%	100%

Oral Surgery includes extractions and other listed oral surgery procedures (including pre- and post-operative care) only when provided in a dentist's office.

Surgical access of an unerupted tooth is a covered benefit only when rendered for orthodontic reasons.

XI. ORTHODONTICS (D8000 - D8999)

	Only if specifically included in the Dental Plan Specifications	50%	50%	50%

XII. ADJUNCTIVE GENERAL SERVICES (D9000 - D9999)

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
UNCLASSIFIED TREATMENT				
9110	Palliative (emergency) treatment of dental pain - minor procedure	100%	100%	100%
ANESTHESIA				
9220	Deep sedation/general anesthesia - first 30 minutes	100%	100%	100%
9221	Deep sedation/general anesthesia - each additional 15 minutes	100%	100%	100%
9241	Intravenous conscious sedation/analgesia – first 30 minutes	100%	100%	100%

CODE	PROCEDURE	DELTA DENTAL PPO DENTIST Co-Payment Percentage	DELTA DENTAL PREMIER DENTIST Co-Payment Percentage	OUT-OF-NETWORK DENTIST Co-Payment Percentage
9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	100%	100%	100%
PROFESSIONAL CONSULTATION				
9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	100%	100%	100%
PROFESSIONAL VISITS				
9450	Case presentation, detailed and extensive treatment planning	100%	100%	100%

General anesthesia and intravenous sedation are a covered benefit when provided in conjunction with Oral Surgery procedures (other than procedure codes 7111 and 7140) that are listed in this Schedule of Dental Benefits.

APPENDIX B
EXCLUSIONS

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.
- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.
- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.
- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.
- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.
- The repair of any component of a cast restoration is not a covered benefit.
- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.
- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.
- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.
- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.
- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.

- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months following initial placement of existing appliance is not a covered benefit.

- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.

- Any prosthodontic appliance connected to an implant is not a covered benefit.

- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.

- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.

- Tissue conditioning is not a covered benefit.

- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.

- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants.*

- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement and a Subscriber elects coverage for dependent children.

- Charges for services completed prior to the date the person became covered under this program.

- Services for anesthetists or anesthesiologists.

- Temporary procedures.

- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).
- Services performed on deciduous (primary) teeth near exfoliation.
- Drugs or the administration of drugs, except for general anesthesia.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.
- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after the *covered individual's effective date of coverage* as a result of war or an act of war.
- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.
- Services and supplies received from either a *covered individual's* or *covered individual's* spouse's relative, any individual who ordinarily resides in the *covered individual's* home or any such similar person.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plaque control programs.
- Services or supplies to correct harmful habits.

APPENDIX C
DENTAL PLAN SPECIFICATIONS

CONTRACT NUMBER: 08331

BENEFIT YEAR: January 1st through December 31st.

DENTAL BENEFITS BOOKLET REISSUANCE DATE: October 1, 2008

ELIGIBILITY REQUIREMENTS:

All present regular, full-time employees of the Group Subscriber who work a minimum of 40 hours per week are eligible for coverage under this Group Dental Plan.

All present employees who are not employed full time as of the Group Plan Commencement Date, but subsequently do become full-time employees, are eligible for coverage under this Group Dental Plan on the date of attainment of full-time status.

All future regular, full-time employees who work a minimum of 40 hours per week become eligible on the date of employment.

Elected officials are eligible for coverage under this Group Dental Plan.

DEPENDENT CHILDREN:

"Dependent children" means those unmarried children who are under the age of 19 or, if full-time students, under the age of 25.

Dependent children shall also include children of any age who are and continue to be permanently and totally disabled because of a medically determinable physical or mental impairment, where the disability commenced prior to losing dependent status as provided above.

Coverage for dependent children terminates the last day of the month in which they attain the limiting age.

DEDUCTIBLE:

IF TREATMENT IS RECEIVED FROM A DELTA DENTAL PPO DENTIST, procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a $25.00 Deductible per Covered Individual per Benefit Period, not to exceed $75.00 per family unit per Benefit Period.*

IF TREATMENT IS RECEIVED FROM A NON-DELTA DENTAL PPO DENTIST, procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a $50.00 Deductible per Covered Individual per Benefit Period, not to exceed $150.00 per family unit per Benefit Period.*

* In the event that some services are provided by a Delta Dental PPO Dentist and others by a Non-Delta Dental PPO Dentist, the deductible is applied as follows:

1. The maximum combined deductible of $50 shall be applied per Covered Individual per Benefit Period, not to exceed $150.00 per family unit per Benefit Period.

2. Should a Covered Individual or family unit change Dentists during a course of treatment, the Covered Individual or family unit shall be subject to the balance of the Deductible, if any, that applies to services provided by the Dentist completing the course of treatment.

The amount a Covered Individual pays for covered Dental Benefits for which the deductible does not apply shall not be applied toward satisfying the deductible amount to other Dental Benefits otherwise covered under this Group Dental Plan.

Covered dental expenses incurred n the last three months of the Benefit Year <u>and</u> applied to a Covered Individual's deductible requirement for that Benefit Year will also be applied to that person's deductible requirement for the following Benefit Year.

COVERAGE LIMITS:

IF TREATMENT IS RENDERED BY A DELTA DENTAL PPO DENTIST, the maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is $1500.00.*

IF TREATMENT IS RENDERED BY A DELTA DENTAL PREMIER OR OUT-OF-NETWORK DENTIST, the maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is $1000.00.*

* In the event that some services are provided by a Delta Dental PPO Dentist and others by a Delta Dental Premier and/or out-of-network Dentist, this Group Dental Plan will only make payment as follows:

1. The combined services cannot exceed the maximum coverage limit (excluding orthodontic benefits) of $1500.00 per Covered Individual per Benefit Period.

2. Once an individual has exhausted $1000.00 of benefits, the remaining $500.00 must be for treatment with a Delta Dental PPO Dentist.

COVERAGE LIMITS - ORTHODONTIA:

IF TREATMENT IS RENDERED BY A DELTA DENTAL PPO DENTIST, lifetime orthodontic benefits payable by Delta Dental per Covered Individual shall not exceed $1200.00. Delta Dental will pay 50 percent of the submitted fee, not to exceed the $1200.00 lifetime maximum per Covered Individual.

IF TREATMENT IS RENDERED BY A DELTA DENTAL PREMIER OR OUT-OF-NETWORK DENTIST, lifetime orthodontic benefits payable by Delta Dental per Covered Individual shall not exceed $1000.00. Delta Dental will pay 50 percent of the submitted fee, not to exceed the $1000.00 lifetime maximum per Covered Individual.

ENHANCED BENEFITS PROGRAM:

Procedures listed in the Schedule of Dental Benefits with a single asterisk (*) are part of the Enhanced Benefits Program. Coverage will be at the group-contracted benefit level, with the additional frequency allowance being the only change. There is no age requirement and the patient may be the Subscriber, or other covered Dependents.