



AGENDA

St. Clair County Board of Commissioners Ways and Means Committee

**Board of Commissioners' Room
County Administrative Office Building, 2nd Floor
200 Grand River Avenue
Port Huron, MI 48060**

December 2, 2021 at 6:00 PM

-
- 1. Roll Call/Opening**
 - 2. Additions/Deletions/Changes to the Agenda**
 - 3. Citizens to be Heard**
 - 4. Updates**
 - 5. Conceptual Initiatives**
 - 6. Old Business**
 - 7. New Business**
 - A. Contract Approval Request - 2022 RESA Service Agreement
 - B. Blue Cross Blue Shield Annual Renewal
 - C. Deltal Dental Contract Renewal
 - D. Medical Examiners - Michigan Forensics, PLLC Addendum #1
 - E. County Clerk Manning Table Change/Addition
 - F. Resolution 21-28 Establishing Per Diems for Boards and Commissions - FINAL ACTION
 - G. Resolution 21-29 Elected Officials Wages for 2022 - FINAL ACTION
 - H. Resolution 21-30 Establishing Wages for CANUE 2022 - FINAL ACTION
 - I. Resolution 21-31 80_20 Cost Sharing Model Adoption - FINAL ACTION
 - 8. Other Ways and Means Matters**
 - 9. Information Only**

10. Receive and File Packets

11. Adjournment

Committee Chair: David Rushing

Note: The County complies with the "Americans with Disabilities Act" and if auxiliary aids or services are required at the meeting for individuals with disabilities, please contact Administrator/Controller's Office, Suite 203, 200 Grand River Avenue, Port Huron, MI 48060, (810) 989-6900 three days prior to said meeting.

Contract Approval Request - 2022 RESA Service Agreement

Summary:

ATTACHMENTS:

Description		Upload Date	Type
📎	Contract Approval Request - RESA Payroll 2022	11/15/2021	Cover Memo
📎	SCC BOC Memo RESA 2022 Agreement	11/15/2021	Cover Memo
📎	2022 St. Clair County Payroll Services (002)	11/15/2021	Cover Memo



COUNTY OF ST. CLAIR
Purchasing Division



CONTRACT APPROVAL REQUEST

- | | | |
|--|--|--|
| ☐ NEW CONTRACT | ☒ CONTRACT RENEWAL | ☐ CONSOLIDATION OF EXISTING CONTRACTS |
| ☐ BIDS REQUIRED | ☒ NO BIDS REQUIRED | |
| ☐ BIDS RECEIVED | ☐ SINGLE SOURCE | |
| ☒ BOC POLICY COMPLIANCE | ☐ CONTRACT EXTENSION | |
| ☒ REVIEWED BY CORP COUNSEL | ☐ INCREASE WITHIN CPI-U | |
| | ☐ VALUE LESS THAN THRESHOLD | |

VENDOR: St. Clair County RESA

VALUE: \$31,500

TERM: 1 year, 1/1/22 – 12/31/22

CONTRACT TYPE: Service Agreement

SERVICE DESCRIPTION: Payroll Services

DEPARTMENT(S): All County Departments

COMMENTS: St. Clair County RESA will continue to provide payroll support as detailed in Attachment A. There is a 3% increase in cost from 2021.



COUNTY OF ST. CLAIR

HUMAN RESOURCES DEPARTMENT



To: St. Clair County Board of Commissioners

From: Diane Barbour, HR Director

Date: November 12, 2021

Subject: Renewal of the St. Clair County Regional Educational Service Agency (RESA) and County of St. Clair Service Agreement

Dear Board of Commissioners,

I would like to request the renewal of the RESA agreement for payroll services for 2022. In this agreement, payroll services will continue same as the 2021 contract.

In 2019 the County's Finance and Payroll software switched to Central Square when it bought One Solution, the former software system. The challenges and problems with Central Square, coupled with poor customer service, have increased the time and number of staff members it takes to complete a payroll cycle.

RESA has proven extremely helpful. RESA's knowledge of the software and the ability to resolve an issue quickly has served us very well during this challenging time. As a result, I am proposing that we utilize their knowledge to continue to resolve issues and their processing services which will allow HR staff to return to normal processing time. In addition and from an audit viewpoint, this will allow an additional check and balance when processing payroll.

This contract has increased slightly for 2022. The cost is \$31,500 for the year which is a 3% increase from 2021.

**St. Clair County Regional Educational Service Agency
St. Clair County**

**Human Resource and Payroll Services
2022**

This Service Agreement is made as of the ____ day of _____ 2021, by the St. Clair County Regional Educational Service Agency (“RESA”) an intermediate service agency and St. Clair County (“County”), a governmental unit recognized by the State of Michigan.

Whereas, the RESA is an intermediate school district as defined by the Revised School Code of 1976, MCL 380.601a and is authorized to enter into agreements or participate in cooperative programs with other entities, public or private, as part of performing the functions of the intermediate school district and in a manner considered by the RESA Board of Education.

Whereas, the County is a governmental subdivision within the State of Michigan and is authorized to participate in cooperative programs with other institutions, public and private, in order to deliver services to its constituent communities and resident; and

Whereas, the County and the RESA have several agreement currently in place covering cooperative projects as well as the provision of services; and

Whereas, the RESA has developed a highly trained and experienced workforce that provides such services to other government units, public school districts, and several non-profit entities at a cost effective level; and

Whereas, the County has determined that utilizing human resources and payroll services from the RESA under this Agreement will be more cost effective and efficient than other options available to the County; and

Whereas, the County desires to secure services in the area of payroll processing and certain human resource services:

Now, and therefore, in consideration of the mutual promises contained in this Service Agreement, the RESA and the County agree as follows:

1. RESA Responsibilities.

The RESA shall be responsible for providing the services as outlined in Attachment A.

2. County Responsibilities.

- a. Provide the necessary payroll information that serves as the basis for the services to be provided by RESA.
- b. Provide to the RESA any and all information relating to the classification, wage scales and benefit packages as well as any collective bargaining agreements with the County’s employees that may be required in order for the RESA to perform the Human Resources services.
- c. The County will provide RESA access to the County Central Square database housed at the County Offices, in order to complete the requested services.

3. Term of the Agreement.

- a. It is understood and agreed that the term of this agreement is intended to cover that period necessary to complete the payroll and human resource services for the 2022 payroll year, (January 1, 2022 through December 31, 2022).
- b. In the event the parties desire to extend the term of this agreement, notice of such intent must be transmitted in writing to the other party, no later than November 1, 2022. Any modifications to the terms and conditions will be mutually agreed upon.

4. Compensation.

- a. The County agrees to pay RESA \$31,500.00 for the services provided for the 2022 payroll year.
- b. The services outlined in this in this agreement are expected to be completed within 350 hours over the course of the year. If it appears that the County requires significantly more than this level, it will be notified in advance so that either an adjustment can be made in the level of services provided or the payment amount can be adjusted accordingly.
- c. The County may engage the RESA for additional services outside the scope of this Agreement. The County will be charged at a rate of \$80.00 per hour.
- d. The RESA will invoice the County on a monthly basis for all services. Payment is expected net 30.

5. Termination.

Either party may terminate this Agreement for any reason with sixty (60) days prior written notice to the other party.

6. No Assignment.

This Agreement or the rights and obligations of either party to this Agreement may not be assigned or transferred to any other person or entity without the prior written consent of the other party hereto.

7. Insurance and Indemnification.

- a. The RESA will be covered at all times during the term of this Agreement by such insurance s it deems adequate in its reasonable judgement.
- b. To the extent permitted by law and subject to paragraph 8, each party agrees to hold harmless and defend the other form any liability, claim or injury, related to or caused by, the fault or negligence of such party's employees or equipment.

8. Limitation of Liability.

In the event the services or system access provided pursuant to this Agreement are delayed or interrupted, for whatever reason, the RESA shall employ reasonable commercial efforts to provide the contracted services as outlined in this agreement. However, notwithstanding, anything contained in this Agreement to the contrary, IN NO EVENT SHALL THE RESA BE LIABLE FOR ANY SPECIAL, INDIRECT, CONSEQUENTIAL,

INCIDENTAL, PUNITIVE, OR EXEMPLARY DAMAGES AS A RESULT OF ANY DELAY OR INTERRUPTION IN THE SERVICES TO BE PROVIDED PURSUANT TO THIS AGREEMENT. The RESA shall be limited in its liability to the County any insurable direct damages for which it is responsible and to the extent, that such damage or injury is compensated, by the RESA's insurance coverage.

9. Notices.

All notices to the RESA shall be sent by certified or registered mail addressed to:

St. Clair County Regional Educational Service Agency
Attention: Superintendent
499 Range Road, PO Box 1500
Marysville, Michigan 48040

or at such other address as the RESA may in writing, from time to time, designate by written notice to the County.

The County shall be sent by certified or registered mail addressed to:

County of St. Clair
Attention: Administrator
200 Grand River Avenue, Suite 203
Port Huron, Michigan 48060

or to such other address as the County may from, time to time, designate by written notice to the RESA.

10. Representations.

Each of the parties represents that, to the best of its knowledge, after due inquiry and investigation, it has the authority to enter into and to perform the responsibilities required by this Agreement and that the representative signing this Agreement has been duly authorized to do so by his/her governing body.

11. Governing Law and Severability.

This Agreement is made under the applicable laws of the State of Michigan and if any term, clause, provision, part or portion of this Agreement shall be adjudged invalid or illegal for any reason, the validity of any other part or portion of this Agreement shall not be affected thereby and the invalid or illegal term, clause, provision, part or portion shall be deleted and ignored as if the same had not been written.

12. Amendments.

This agreement may be altered, modified or amended when mutually agreed to by written instrument signed by RESA and the County.

IN WITNESS OF, the St. Clair County RESA and County have executed this Agreement as of the date first above written.

St. Clair County Regional Educational
Service Agency

St. Clair County

Dr. Kevin D. Miller, Superintendent

Karry Hepting, Administrator/Controller

Date

Date

**St. Clair County Regional Educational Service Agency
St. Clair County**

Attachment A

RESA Payroll Duties

Process year-end 1099's and W-2s – create file, templates, balances and prints.
Set up annual pay schedules and pay periods for retiree and regular employ pays.
Process annual salary table, payroll assignment and benefit utility.
Prepare updates to existing calculation codes.
Update and create new benefit tables (active only).
Payroll CDH codes: Add new and update existing codes.
Quarterly 941's – Balance, Complete and Return to County for submission.
Complete Pay Assignment approvals for payroll activities.
Run payroll re-compute of accumulators bi-weekly.
Balance salary employees each payroll.
Balancing and Processing of bi-weekly regular payrolls as well as supplemental checks.
Create new tax year payroll accumulator screens.
Process void checks for retiree and regular employee checks.
Troubleshoot and correct payroll issues, provide consultation for payroll issues/processes.
Provide support with reports (CDD report creation/support is not included in this agreement).
Software upgrade testing of payroll system (limited to 15 hours).
Processing of Open Enrollment forms in software system.

County Payroll Duties

Payroll communications to department delegates.
Payroll communications with County employees.
Create payroll calendars each fiscal year
Complete and enter payroll activities in software system.
Calculation of retro payments.
Calculation of regular employee garnishments.
Processing of employee reimbursement and adjustment time card batch.
Enter employee tax requests, direct deposits and miscellaneous deductions.
Collection of payroll timecard batches and review.
Completion of timecard batch balancing spreadsheet.
Responsible for processing payroll EFT file with bank.
Terminate and inactivate employee records.

Blue Cross Blue Shield Annual Renewal

Summary:

ATTACHMENTS:

	Description	Upload Date	Type
📎	TDelia Memo to Board Re BCBS-Dental Renewal 2022 PY	11/22/2021	Cover Memo
📎	130983_BCBSM_2022_ASC_PKG_COUNTY OF ST CLAIR	11/22/2021	Cover Memo



COUNTY OF ST. CLAIR

HUMAN RESOURCES DEPARTMENT



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www.stclaircounty.org

To: St. Clair County Board of Commissioners

From: Tina Delia, Sr. HR Specialist

Date: November 19, 2021

Subject: Blue Cross Blue Shield & Delta Dental Annual Renewal

The attached Blue Cross Blue Shield Schedule A Renewal and Stop Loss Exhibit reflects the administrative and stop loss fees to be paid per contract per month for employees and non-Medicare eligible retirees for the 2022 plan year. The administrative fee is increasing by 3% and the stop loss fee is increasing by 9.3%. However, this increase in fees will be offset by favorable claims experience and the 2022 prescription drug rebates estimated at \$679,000. All of these changes have been factored into the employee premium share calculation for 2022, resulting in a minimal increase of less than 0.3% for employees.

The stop loss level for 2022 will remain at \$160,000 and includes coverage for medical and prescription drug claims.

The attached Delta Dental renewal includes a three year rate hold at our current administrative fee of \$4.07 per month per contract for employees and retirees.

RECOMMENDATION: Human Resources recommends that the Board of Commissioners approve the Blue Cross Blue Shield and Delta Dental 2022 renewal documents as presented.

Blue Cross Blue Shield of Michigan
SCHEDULE A – Renewal Term (Effective 01/01/2022 thru 12/31/2022)
Administrative Services Contract (ASC)

1. **Group Name** COUNTY OF ST CLAIR
2. **Customer ID** 130983
3. **ASC Funding Arrangement** Weekly Invoice
4. **Line(s) of Business and Services**

Line of Business	Applicable
Facility	X
Professional	X
Prescription Drugs	X
Dental	
Vision	X
Hearing	X

Services	Applicable
Prescription Drug Guarantee Addendum	X

5. Administrative Fees

The below administrative fees cover the Lines of Business and Services checked in Section 4 above, unless otherwise indicated.

A. Fixed Administrative Fees	Amount Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Admin Fee	Effective Start Date	Effective End Date
i. 2022 Base Admin Fee	\$73.02	663	\$48,412.26	01/01/2022	12/31/2022

B. Variable Administrative Fees – Not Applicable

6. **Data Feeds – Not Applicable**
7. **Advance Deposit – Not Applicable**
8. **Advance Deposit Monthly Cap / Level Payment Amount – Not Applicable**
9. **BCBSM Account**

1840-09397-3

Wire Number

Comerica

Bank

0720-00096

American Bank Association

10. Late Payment / Interest Charges

Late Payment Charge	2.00%
Health Care Provider Interest Charge	12.00%

11. Buy-Ups

A. Programs	Pricing Method	Unit Price	Unit Volume	Amount	Effective Start Date	Effective End Date
Diabetes Mgmt: Livongo Classic	PPPM	\$0.00	--	--	01/01/2022	12/31/2022
Diabetes Prevention: Omada	PPPM	\$0.00	--	--	01/01/2022	12/31/2022
Online Visits	PCPM	\$0.20	663	\$132.60	01/01/2022	12/31/2022

12. Shared Savings Programs

BCBSM has implemented programs to enhance the savings realized by its customers. As stated below, BCBSM will retain as administrative compensation a percent of the recoveries or cost avoidance. Administrative compensation retained by BCBSM through the Shared Savings Program will be available through reports obtained on eBookshelf:

Program:	BCBSM Retention of:	
A. Hospital Bill Review	30%	Cost avoidance of improper hospital billing by line-by-line reviews of each inpatient claim's itemized bill to identify defects and improprieties before the bill is paid.
B. Advanced Payment Analytics	30%	Recoveries of overpayments using proprietary data mining analytics as a second pass review along with continual monitoring enabling up-to-date policy compliance.
C. Subrogation	30%	Recoveries of money already paid through Blue Cross benefits that is the responsibility of non-health insurance carrier.
D. Hospital Credit Balance	30%	Recoveries of claims through enhanced reviews of hospital patient accounting systems and identified credit balances from overpayments.
E. Advanced Editing	30%	Cost avoidance through applied advanced algorithms and extensive analytic reviews of professional and outpatient facility Claims for adherence to medical, clinical and national coding guidelines.
F. Non-Participating Provider Negotiated Pricing	30%	Cost avoidance for out-of-network, non-participating Claims equal to the difference between the amount that would have been paid pursuant to the Group's benefit design (before Enrollee cost-share is applied) and the amount actually paid for such Claims (before Enrollee cost-share is applied) as a result of third-party vendor negotiations or benchmark-based pricing.
G. Home Infusion Therapy Medical Drugs	30%	The difference between BCBSM's 2021 home infusion therapy ("HIT") network pricing and the improved negotiated pricing administered through a third party HIT vendor.
H. Rebate Service Fee for Medical Prescription Drugs	10%	Medical benefit drug rebates on Claims incurred in the renewal term net of the Rebate Administrator Fee. The Rebate Administrator Fee is 5.25% of gross rebates for medical benefit drug Claims.
I. Rebate Service Fee for Pharmacy Prescription Drugs	10%	Pharmacy benefit manufacturer rebates on Claims incurred in the renewal term.

13. Pharmacy Pricing Arrangement

A. Traditional Prescription Drug Pricing and Administrative Compensation

Group acknowledges and agrees the amount BCBSM pays its contracted pharmacy benefit manager (“PBM”) for a prescription drug may be more or less than the amount Group pays BCBSM for such prescription drug, and BCBSM may retain the difference as administrative compensation as specified below, when the amount is less.

BCBSM shall retain the following administrative compensation (“Traditional Rx Drug Pricing Admin Fee”):

- a. Up to 1.95 percentage points of the aggregated Average Wholesale Price (“AWP”) discount BCBSM receives from its PBM for drugs classified by BCBSM as retail or mail order Brand Drugs; and
- b. Up to four (4) percentage points of the aggregated AWP discount BCBSM receives from its PBM for drugs classified by BCBSM as retail or mail order Generic Drugs.
- c. \$0.10 of the dispensing fee for 30-day supplies of retail prescription drugs.

The actual Traditional Rx Drug Pricing Admin Fee paid by Group to BCBSM shall depend on Group’s aggregated AWP discount referenced above, which is based on Group’s prescription drug utilization, drug mix, pharmacy choice, and a pharmacy’s usual and customary charges. BCBSM will credit Group with any amount that was collected during the Contract Year that exceeds the amounts specified in (a) and (b) above. The Traditional Rx Drug Pricing Admin Fee retained by BCBSM will be reported to the Group.

Group agrees to timely incorporate language into Group’s Summary Plan Description or equivalent document that any Enrollee cost-sharing that is calculated as a percentage will be based upon the amount Group pays BCBSM for the prescription drug.

B. Pharmacy Monitoring Fee (PMF) Pricing – *Not Applicable*

14. Additional Pharmacy Services and/or Programs

A. 3rd Party Rx Vendor Fee

If Group’s prescription drug benefits are administered by a third-party vendor, BCBSM will charge Group an administrative fee of \$5.00 per contract per month due to the additional costs and resources necessary for BCBSM to effectively manage and administer the medical benefit without administering the prescription drug benefit.

B. High-Cost Drug Discount Optimization Program

The High-Cost Drug Discount Optimization Program uses coupons available from pharmaceutical manufacturers to reduce the cost of certain prescription drugs for Enrollees and the Group.

Group will pay BCBSM twenty five percent (25.00%) (“Program Fee”) of the difference between the amount Group would have paid for the prescription drug and the amount Group actually paid after the coupon is applied to reduce the cost of the drug. The Program Fee will be billed to Group as a line item on its invoice.

15. 3rd Party Stop-Loss Vendor Fee

If Group obtains stop-loss coverage from a third-party stop-loss vendor, BCBSM will charge an additional fee of \$8.00 per contract per month due to the additional costs and resources necessary for BCBSM to effectively manage Group’s benefits.

16. Agent Fees

This Schedule A does not include any fees payable by Group to an Agent. If Group has an Agent Fee Processing Agreement on file with BCBSM, please refer to that agreement for fees and details.

17. Medicare Contracts

If Group has Medicare contracts that are being separated from the current funding arrangement, all figures within the current funding arrangement will be adjusted.

18. Compensation Agreement with Providers

The Group acknowledges that BCBSM or a Host Blue may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced. The Claims billed to Group include both service-based and value-based reimbursement to health care providers. Group acknowledges that BCBSM's negotiated reimbursement rates include all reimbursement obligations to providers including provider obligations and entitlements under BCBSM Quality Programs. Service-based reimbursement means the portion of the negotiated rate attributed to a health care service. Value-based reimbursement is the portion of the negotiated reimbursement rate attributable to BCBSM Quality Programs, as described in Exhibit 1 to Schedule A. BCBSM negotiates provider reimbursement rates and settles provider obligations on its own behalf, not Group. Group receives the benefit of BCBSM provider rates, but it has no entitlement to a particular rate or to unbundle the service-based or value-based components of Claims.

BCBSM Quality Programs may also include risk sharing arrangements with certain provider entities ("PE"), e.g., physician organizations, facilities, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside risk for a performance year. The PE's performance will be measured by comparing its total cost of care trend for attributed members to BCBSM's statewide total cost of care trend which may be equated to a per member per month amount. BCBSM will calculate each PE's performance approximately 11 months after the end of a performance year.

If the PE's performance results in a payment of additional reimbursement, Group may be invoiced an additional amount based on its attributed membership to that PE. If the PE's performance results in a return of reimbursement, Group may receive a credit based on its attributed membership to that PE. BCBSM will provide Group with supporting documentation for such amounts. Invoice or credit to Group may occur in conjunction with BCBSM's customer savings refund process as set forth in the administrative services contract.

Notwithstanding the above, in the first three years of the program (2020-2022), BCBSM will not invoice Group for any additional reimbursement earned by a PE. Moreover, reimbursement returned to BCBSM may be used to offset any additional reimbursement earned by a PE in the following year. BCBSM will not retain any amounts resulting from such risk sharing arrangements.

See Schedule B to ASC and Exhibit 1 to Schedule A for additional information.

19. Out-of-State Claims

Amounts billed for out-of-state claims may include BlueCard access fees and any value-based provider reimbursement negotiated by a Host Blue with out-of-state providers. See Schedule B to ASC and Exhibit 1 to Schedule A for additional information.

Exhibit 1 to the Schedule A: Value-Based Provider Reimbursement

As in prior years, the Claims billed to Group include amounts that BCBSM reimburses health care providers including reimbursement tied to value. BCBSM has adopted a provider payment model that includes both fee-based and value-based reimbursement. BCBSM does not unbundle Claims and does not retain any portion of Claims as compensation. Provider reimbursement is governed by separate agreements with providers, BCBSM standard operating procedures, and BCBSM Quality Programs, which are subject to change at BCBSM's discretion. BCBSM shall provide Group with at least sixty (60) days' advance written notice of any additions, modifications or changes to BCBSM Quality Programs describing the change and the effective date thereof.

BCBSM negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCBSM Quality Programs, including, for example, Pay-for-Performance (PFP) rates and Value Based Contracting (VBK) rates earned by hospitals, Per Attributed Per Member Per Month ("PaMPM") Provider Delivered Care Management, and Patient Centered Medical Home (PCMH) rates earned by physicians. Provider reimbursement rates also capture provider commitments to BCBSM Quality Program, such as participation and performance in Collaborative Quality Initiatives ("CQIs"). CQIs address many of the most common and costly areas of surgical and medical care in Michigan. In each CQI, hospitals and physicians across the state collect, share and analyze data on patient risk factors, processes of care and outcomes of care, then design and implement changes to improve patient care.

Providers may also receive reward and incentive payments from BCBSM Quality Programs funded through an allocation from provider reimbursement or collected from Group's Customer Savings Refund. Such allocations may be to a pooled fund from which value-based payments to providers are made. For example, pursuant to the Physician Group Incentive Program (PGIP), physicians agree to allocate a percentage of each Claim to a PGIP fund. The PGIP fund makes reward payments to eligible physician organizations demonstrating particular quality, pays physician organizations for participation in collaborative initiatives, and funds CQIs. An additional portion of a provider's contractual reimbursement (the "Risk Allocation") of most claims may be allocated to a Risk Pool for payments to organized systems of care based on cost/quality performance.

BCBSM Quality Programs may also include risk sharing arrangements with certain provider entities ("PE"), e.g., physician organizations, facilities, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside risk for a performance year. The PE's performance will be measured by comparing its total cost of care trend for attributed members to BCBSM's statewide total cost of care trend which may be equated to a per member per month amount. BCBSM will calculate each PE's performance approximately 11 months after the end of a performance year.

If the PE's performance results in a payment of additional reimbursement, Group may be invoiced an additional amount based on its attributed membership to that PE. If the PE's performance results in a return of reimbursement, Group may receive a credit based on its attributed membership to that PE. BCBSM will provide Group with supporting documentation for such amounts. Invoice or credit to Group may occur in conjunction with BCBSM's custom savings refund process as set forth in the administrative services contract.

Notwithstanding the above, in the first three years of the program (2020-2022), BCBSM will not invoice Group for any additional reimbursement earned by a PE. Moreover, reimbursement returned to BCBSM may be used to offset any additional reimbursement earned by a PE in the following year. BCBSM will not retain any amounts resulting from such risk sharing arrangements.

As explained in the Blue Card Program disclosure ([Schedule B to ASC](#)), an out-of-state Blue Cross Blue Shield Plan ("Host Blue") may also negotiate fee-based and/or value-based reimbursement for their providers. A Host Blue may include all provider reimbursement obligations in Claims or may, at its election, collect some or all of its value-based provider (VBP)

reimbursement obligations through a PaMPM benefit expense, as in, for example, the Total Care Program. All Host Blue PaMPM benefit expenses for VBP reimbursement will be consolidated on your monthly invoice and appear as “Out-of-State VBP Provider Reimbursement.” The supporting detail for the consolidated amount will be available on e-Bookshelf as reported by each Host Blue Plan. Host Blues determine which members are attributed to eligible providers and calculate the PaMPM VBP reimbursement obligation based only on these attributed members. Host Blue have exclusive control over the calculation of PaMPM VBP reimbursement.

Value-based reimbursement includes other obligations and entitlements pursuant to other BCBSM Quality Programs funded in a similar manner to those described in this Exhibit. Additional information is available at www.valuepartnerships.com and www.bcbs.com/totalcare. Questions regarding provider reimbursement and BCBSM Quality Programs or Host Blue VBP reimbursement should be directed to your BCBSM account representative.

Intellectual property may be developed through BCBSM Quality Programs for subsequent license and use by BCBSM or a third party. Group specifically understands, acknowledges, and agrees that it has no rights to any intellectual property, or derivatives thereof, including, but not limited to, copyrights, patents, or licenses, developed thru BCBSM Quality Programs.

BLUE CROSS BLUE SHIELD OF MICHIGAN
Exhibit 2 to Schedule A
For Effective 1/1/2022 – 12/31/2022

- | | |
|---------------|--------------------|
| 1. Group Name | COUNTY OF ST CLAIR |
| 2. CID | 130938 |

This Exhibit 2 to Schedule A modifies and/or supplements the 2022 Schedule A based on any non-standard arrangements with Group. If there is a conflict between the terms of the Schedule A and this Exhibit 2, the terms of this Exhibit 2 will control and govern the rights and obligations of the parties.

1. Modifications to Schedule A:
 - a. Section 11 is modified to add the following:

Livongo Diabetes Management Buy-Up Program

Group has elected to participate in the Livongo Diabetes Management Program (the “Program”). The Program is a remote monitoring and diabetes self-management coaching program designed to target diabetic Enrollees (as that term is defined in the administrative services contract) regardless of HbA1c levels. The Program provides those Enrollees that opt-in to the Program (“Participants”) with a downloadable app, a remote monitoring device, lancing device and test strips. The app tracks the Participant’s blood sugar related to what the Participant has been doing and what the Participant is feeling during a reading. The Participant can share alerts and data from the app with family and/or treating providers. The Participant also has access to a 24/7 call center that provides coaching and educates the Participant on maintaining their blood sugar at appropriate levels and can respond to alerts of high or low blood sugar.

The Program services for each Participant will be billed to Group as a claim at a cost of sixty-seven dollars (\$67.00) per Participant per month (PPPM). Group will be billed for: (i) three calendar months following a Participant’s initial enrollment in the Program (“Initial Enrollment Period”), (ii) all calendar months beyond the Initial Enrollment Period for which the Participant remains active in the Program, and (iii) any calendar month (for up to three consecutive months) beyond the Initial Enrollment Period for which the Participant is inactive and Livongo reaches out to the Participant to reengage the Participant in the Program. An inactive Participant is a Participant who has not completed a blood glucose check, interacted with a Livongo coach, or logged into the Livongo portal or mobile app during a calendar month.

Group will be billed at a cost of one hundred sixty-seven dollars (\$167.00) for a one-time replacement of the remote monitoring device if the device has been lost, stolen or damaged in a way that is not covered by warranty.

Group acknowledges and agrees that BCBSM will not perform any coordination of benefit activities for Program claims, and Group will pay for all Program claims.

Livongo will pay BCBSM up to ten dollars (\$10.00) per Participant per month for BCBSM’s administrative services to the Program.

b. Section 11 is modified to add the following:

Omada Diabetes Prevention Buy-Up Program

Group has elected to participate in the Omada Diabetes Prevention Program (the "Program"). The Program provides Enrollees (as that term is defined in the administrative services contract) who complete the enrollment process ("Participants") with a digitally based behavioral change program that includes professional health coaching and tools to track diet improvements, physical activity and weight loss. The goal of the Program is for the Participant to lose weight and prevent the progression to type 2 diabetes and associated complications. The Program targets at-risk members based on their BMI and lab values (if appropriate).

The Program services for each Participant will be billed to Group as a claim as follows:

- a. \$240 per Participant upon initial enrollment;
- b. a per Participant per month amount of \$14 multiplied by the Participant's Monthly Result Amount for the Participant's first twelve months in the Program; and
- c. a per Participant per month amount of \$7 multiplied by the Participant's Monthly Result Amount after the Participant's first twelve months in the Program.

The following definitions will apply when calculating the Monthly Result Amount:

- a. Monthly Result Amount: Participant's Monthly Percentage Weight Loss for such month multiplied by 100 and rounded down to the nearest whole number.
- b. Monthly Percentage Weight Loss: The percent obtained by dividing the amount by which Participant's Baseline Weight exceeds such Participant's Median Weight for a calendar month by Participant's Baseline Weight. In the event that a Participant's Median Weight during a calendar month is equal to or greater than such Participant's Baseline Weight, such Participant's Monthly Percentage Weight Loss for such calendar month shall be zero.
- c. Median Weight during calendar month: The median value among all valid weight measurements (which must be based upon a minimum of three valid weight measurement values) registered for a Participant during a calendar month.
- d. Baseline Weight: Participant's weight at the beginning of Participant's enrollment in the Program based on data obtained by Omada from the Participant using Omada's digital scale.

Group acknowledges and agrees that BCBSM will not perform any coordination of benefit activities for Program claims to the extent a Participant has other primary coverage, and Group will pay for all Program claims.

Omada will pay BCBSM ten dollars (\$10.00) per Participant for BCBSM's administrative services to the Program.

Schedule B
BlueCard Disclosures
Inter-Plan Arrangements

Out-of-Area Services

Overview

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Enrollees access healthcare services outside the geographic area BCBSM serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSM for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSM serves, Enrollees obtain care from Providers that have a contractual agreement (“Participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Enrollees may obtain care from Providers in the Host Blue geographical area that do not have a contractual agreement (“Nonparticipating Providers”) with the Host Blue. BCBSM remains responsible for fulfilling its contractual obligations to you. BCBSM’s payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that Dental Care Benefits, except when paid as medical claims / benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSM to provide the specific service or services, are not processed through Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Enrollees access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

a. Enrollee Liability Calculation

The calculation of the Enrollee liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the Participating Provider’s billed covered charges or the negotiated price made available to BCBSM by the Host Blue.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue’s local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider’s billed charge and the reference

benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

b. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

2. Claims Pricing

The Host Blue determines a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to BCBSM by the Host Blue may be represented by one of the following:

- (i) an actual price. An actual price is a negotiated payment in effect at the time a Claim is processed without any other increases or decreases, or
- (ii) an estimated price. An estimated price is a negotiated payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or
- (iii) an average price. An average price is a percentage of billed charges for covered services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or an average price in its respective Provider agreements. The use of estimated or average pricing may result in a difference (positive or negative) between the price Group pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Enrollee and Group is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Group will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Group. If Group terminates, Group will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume / number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. The Host Blue may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which BCBSM is obligated under the BlueCard Program to pay to the Host Blue, to the Blue Cross and Blue Shield Association (BCBSA), and/or to vendors of BlueCard Program related services. The specific Blue Card Program fees and compensation that are charged to Group and which Group is responsible related to the foregoing are set forth in Exhibit 1 to this Schedule B. BlueCard Program Fees and compensation may be revised annually from time to time as described in H below.

B. Negotiated Arrangements

With respect to one or more Host Blue, instead of using the BlueCard Program, BCBSM may process your Enrollee claims for covered healthcare services through Negotiated Arrangements.

In addition, if BCBSM and Group have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in BCBSM's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Enrollees access such network(s). In negotiating such arrangement(s), BCBSM is not acting on behalf of or as an agent for Group, the Group's health care plan or Group Enrollees.

1. Enrollee Liability Calculation

Enrollee liability calculation for covered healthcare services will be based on the lower of either billed covered charges for covered services or negotiated price that the Host Blue makes available to BCBSM that allows Group's Enrollees access to negotiated participation agreement networks of specified Participating Providers outside of BCBSM's service area.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

2. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

3. Claims Pricing

Same as in the BlueCard Program above.

4. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangement may be revised annually as described in section H below. In addition, the participation agreement with the Host Blue may provide that BCBSM must pay an administrative and/or a network access fee to the Host Blue, and Group further agrees to reimburse BCBSM for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Group under the Negotiated Arrangements are set forth in Exhibit 1 to this Schedule B.

C. Special Cases: Value-Based Programs

Value-Based Programs Overview

Group Enrollees may access covered healthcare services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways, including but not limited to retrospective settlements, Provider Incentives, share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to BCBSM, which BCBSM will pass directly on to Group as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

- (i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Group via an enhanced Provider fee schedule.
- (ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the Claim, they may be billed as a Per Attributed Member Per Month (PaMPM) amount for Value-Based Programs incentives/Shared Savings settlements to Group outside of the Claim system. BCBSM will pass these Host Blue charges directly through to Group as a separately identified amount on the Group's invoices.

The amounts used to calculate either the supplemental factors for estimated pricing or PaMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, the Host Blue will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PaMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PaMPM price methods, described above, are calculated. If Group terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of the administrative services contract.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated / drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume / number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. The Host Blue may retain interest earned on funds held in variance accounts.

Note: Enrollees will not bear any portion of the cost of Value-Based Programs except when the Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

The Host Blue may also bill BCBSM for Care Coordinator Fees for Covered Services which BCBSM will pass on to Group as follows:

1. PaMPM billings; or
2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of this agreement / contract, BCBSM and Group will not impose Enrollee cost sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If BCBSM has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to Enrollees, BCBSM will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

D. Return of Overpayments

Recoveries of overpayments from a Host Blue or its Participating Providers and Nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from the Host Blue to BCBSM they will be credited to the Group account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments or recovery amounts. The fees of such a third party may be charged to Group as a percentage of the recovery.

Unless the Host Blue agrees to a longer period of time for retroactive cancellations of membership, the Host Blue will provide BCBSM the full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, BCBSM will request such refunds for a period of up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this agreement / contract.

E. Inter-Plan Programs: Federal / State Taxes / Surcharges / Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSM will provide prior written notice of any such surcharge, tax or other fee to Group, which will be Group liability.

F. Nonparticipating Healthcare Providers Outside BCBSM's Service Area

1. Enrollee Liability Calculation

a. In General

When covered healthcare services are provided outside of BCBSM's service area by Nonparticipating Providers, the amount an Enrollee pays for such services will generally be based on either the Host Blue's Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, BCBSM may pay Claims from Nonparticipating Providers outside of BCBSM's service area based on the Provider's billed charge, such as in situations where an Enrollee did not have reasonable access to a Participating Provider, as determined by BCBSM in BCBSM's sole and absolute discretion or by applicable state law. In other exception cases, BCBSM may pay such Claims based on the payment BCBSM would make if BCBSM were paying a Nonparticipating Provider inside of its service area where the Host Blue's corresponding payment would be more than BCBSM's in-service area Nonparticipating Provider payment. BCBSM may choose to negotiate a payment with such a Provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph.

2. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group and that Group will be responsible for in connection with the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in H below.

G. Blue Cross Blue Shield Global Core (Formerly known as BlueCard Worldwide® Program)

1. General Information

If Enrollees are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists Enrollees with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Enrollees receive care from Providers outside the BlueCard service area, the Enrollees will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Enrollees contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Enrollees to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit Enrollee Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Enrollee paid in full at the time of service, the Enrollee must submit a Claim to obtain reimbursement for covered healthcare services. Enrollees must contact BCBSM to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Enrollees to pay in full at the time of service. Enrollees must submit a Claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Enrollees pay for covered healthcare services outside the BlueCard service area, they must submit a Claim to obtain reimbursement. For institutional and professional claims, Enrollees should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSM, the Blue Cross Blue Shield Global Core Service Center, or online at www.bcbsglobal.com. If Enrollees need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. Blue Cross Blue Shield Global Core Program-Related Fees

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group under the Blue Cross Blue Shield Global Core Program and that Group is responsible for relating to the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section H below.

H. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, BCBSM shall provide Group with at least sixty (60) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Group right to terminate the ASC without penalty by giving written notice of termination before the effective date of the change. If Group fails to respond to the notice and does not terminate the ASC during the notice period, Group will be deemed to have approved the proposed changes, and BCBSM will then allow such modifications to become part of the ASC.

Exhibit 1

BlueCard Program Access Fees may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in BCBSM's administrative fee, unless otherwise agreed to by Group. The BlueCard Access Fee is charged by the Host Blue to BCBSM for making its applicable Provider network available to Group's Enrollees. The BlueCard Access Fee will not apply to Nonparticipating Provider Claims. The BlueCard Access Fee is charged on a per-Claim basis and is charged as a percentage of the discount / differential BCBSM receives from the applicable Host Blue and is capped at \$2,000.00 per Claim. The percentages for 2022 are:

1. 3.79% for fewer than 1,000 PPO or traditional enrolled Blue contracts;
2. 2.11% for 1,000–9,999 Blue PPO or traditional enrolled Blue contracts;
3. 1.96% for 10,000–49,999 Blue PPO or traditional enrolled Blue contracts;

For Groups with 50,000 or more Blue PPO or Traditional enrolled contracts, Blue Card Access Fees are waived and not charged to the Group. If Group's enrollment falls below 50,000 PPO enrolled contracts, BCBSM passes the BlueCard Access Fee, when charged, directly on to the Group.

Instances may occur in which the Claim payment is zero or BCBSM pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, BCBSM will pay the Host Blue's Access Fee and passes it directly on to the Group as stated above even though the Group paid little or had no Claim liability.



STOP-LOSS INSURANCE POLICY
between

BLUE CROSS BLUE SHIELD OF MICHIGAN
a Nonprofit Mutual Insurer

Herein called "the Company"

and

COUNTY OF ST CLAIR

Herein called "the Policyholder"

The Exhibit attached hereto and made a part of this Policy shall establish the Policyholder's Group Name, Customer ID, and the Policy Period.

In consideration of the Exhibit attached hereto and in consideration of the payment made by the Policyholder of all premiums when due as hereinafter provided, the Company agrees to make the payments herein specified, subject to the provisions and conditions of this Policy.

All definitions of the administrative services contract between the Policyholder and the Company (herein called the "Contract") shall apply equally to this Policy unless otherwise specified in this Policy or the Exhibit.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Policy is exempt from the filing requirements of Section 2236 of the Insurance Code of 1956, 1956 PA 218, MCL 500.2236.

SECTION I

DEFINITIONS

Additional definitions applicable to this Policy are contained in the Contract.

1. **"Additional Administrative Compensation" or "AAC"** has the meaning as defined in the applicable Contract.
2. **"Aggregate Attachment Point"** means the dollar amount above which Aggregate Stop-Loss Coverage will apply. The Aggregate Attachment Point is the product of (a) the average number of Coverage Units per month for the Policy Period, (b) the expected Claims per Coverage Unit for the Policy Period and (c) the attachment point percentage listed in Item A of the Exhibit to this Policy provided, however, that the Aggregate Attachment Point shall never be less than the Minimum Aggregate Attachment Point specified in Item A.4. of the Exhibit.
3. **"Aggregate Stop-Loss Coverage"** means the Amounts Billed during the Policy Period (less Specific Stop-Loss Claims, if any) that exceed the Aggregate Attachment Point. For any aggregate credits to be provided, a twelve-month Policy Period is required.
4. **"Aggregating Specific Deductible"** means a deductible, in addition to the Specific Attachment Point, that must be satisfied during the Policy Period before Amounts Billed are credited under this Policy.
5. **"Amounts Billed"** means paid Claims, including any adjusted and re-adjudicated Claims, in addition to the combined amount of BlueCard Fees and AAC, if any. AAC and/or BlueCard Fees shall only be included as "Amounts Billed" where such AAC or fees are paid in association with the types of Claims Covered and in settlement of Claims for any benefits under the Plan, and are:
 - (a) In the case of new coverage or existing customer adding stop-loss coverage: (i) incurred and paid during the Policy Period or (ii) incurred prior to and paid during the Policy Period for which Policyholder is not reimbursed or paid by the prior stop-loss carrier, as specified on the Exhibit.
 - (b) In the case of a renewal of existing coverage, incurred on or after the Original Effective Date of Policy and paid during the Policy Period, as specified on the Exhibit.
 - (c) Paid during the Run-Out Period, where applicable, in accordance with the provisions of this Policy.

Claims, AAC, and BlueCard Fees are considered "incurred" on the date the associated service or supply is furnished; Claims, AAC, and BlueCard Fees are considered "paid" on the date they are processed.
6. **"Amounts Billed"** shall not include:
 - (a) AAC or BlueCard Fees associated with claims incurred prior to the Original Effective Date of Policy, except as specified on the Exhibit;
 - (b) AAC or BlueCard Fees associated with claims incurred after the termination date of this Policy;
 - (c) Extra-contractual damages of any nature, compensatory damages, punitive damages, or any similar damages however assessed (including as a result of settlement), or any payments made as an exception to the Plan;
7. **"BCBS Plan"** means a company that has been licensed by the Blue Cross and Blue Shield Association ("BCBSA").

8. **"BlueCard Fees"** means the fees assessed under the national program established by BCBSA under which BCBS Plan Enrollee claims are processed by BCBS Plans when an Enrollee receives health care services outside of the area served by their BCBS Plan.
9. **"Claim"** means "Claim" as that term is defined in the Contract for the lines of business specified in Items A.2 and/or B.2 in the Exhibit.
10. **"Claims Covered"** means the coverage specified in Items A.1. and/or B.1. of the Exhibit.
11. **"Coverage Unit"** means an Employee plus such person's eligible enrolled dependents. Those dependents are not counted separately but are included within the Employee's "Coverage Unit."
12. **"Enrollee"** means "Enrollee," as that term is defined in the Contract unless the Contract provides coverage for inmates of a penal institution, in which case "Enrollee" means "Inmate," as defined in such Contract.
13. **"Effective Date of Policy"** means the Policy Period start date referenced in the Exhibit.
14. **"Employee"** means "Employee," as that term is defined in the Contract unless the Contract provides coverage for inmates of a penal institution or participants in a Trust Fund, in which case "Employee" means "Inmate" or "Participants," as defined in the relevant Contract.
15. **"Exhibit"** means the attached Exhibit to the Stop-Loss Coverage Policy or any subsequent replacement Exhibit supplied by the Company. The specifications or items of the Exhibit shall be applicable for the Policy Period indicated on the Exhibit, except that any item of the Exhibit may be changed in accordance with the provisions described in this Policy.
16. **"Final Policy Period"** means the period of time beginning on the first day of the Policy Period specified on the Exhibit and ending on the date the Policy is terminated.
17. **"Minimum Aggregate Attachment Point"** is the minimum Claims amount shown in Item A.4 of the Exhibit that must be paid by the Policyholder before Aggregate Stop-Loss Coverage is credited. The Minimum Aggregate Attachment Point is 90 percent of a) the Aggregate Attachment Point as shown in Item A.3. of the Exhibit on a per Coverage Unit basis times b) the number of Coverage Units as shown in Item A.6. of the Exhibit.
18. **"Month"** means each succeeding calendar month period beginning on the first day of the Policy Period.
19. **"Original Effective Date of Policy"** means the date the Policyholder became a Blue Cross Blue Shield of Michigan stop-loss insurance policyholder. If stop-loss coverage was terminated for any reason, the Original Effective Date of Policy means the start date of the most recent uninterrupted policy periods.
20. **"Plan"** shall mean the self-funded group health plan of the Policyholder.
21. **"Policy"** as used herein means this Stop-Loss Insurance Policy.
22. **"Policy Period"** means the period of coverage beginning and ending on the dates shown on the Exhibit.
23. **"Proof of Loss"** means evidence of the Plan's payment or liabilities of Amounts Billed by or on behalf of an Enrollee during the Policy Period.
24. **"Run-In Period"** means the period immediately prior to the initial Policy Period, if any, as specified in Item B.1. of the Exhibit.

25. **“Run-Out Amounts Billed”** means those Amounts Billed that are incurred on or after the Original Effective Date of Policy but prior to termination and that are paid during the Run-Out Period.
26. **“Run-Out Period”** means the 24-month period immediately following the termination of this Policy.
27. **“Specific Attachment Point”** means the dollar amount above which Specific Stop-Loss Coverage will apply as shown in Item B.3 of the Exhibit.
28. **“Specific Stop-Loss Coverage”** means the Amounts Billed during the current Policy Period in excess of the Specific Attachment Point and the Aggregating Specific Deductible in Item B.4. of the Exhibit, if applicable, per Policy Period.
29. **“Stop-Loss Claims”** means the Amounts Billed for which the Company assumes responsibility and risk.
- (a) If the Amounts Billed that have accumulated during the Policy Period for any Coverage Unit exceed the amount indicated in Item B.3. and the Aggregating Specific Deductible indicated in Item B.4., if applicable, of the Exhibit to this Policy, such excess, up to the maximum amounts indicated, if any, shall be referred to in this Policy as Specific Stop-Loss Claims. A monthly review will occur to determine if such excess exists.
 - (b) Specific Stop-Loss Coverage does not extend beyond the termination date of this Policy unless coverage for Run-Out Stop-Loss Insurance is elected at least twelve months prior to termination of the Contract.
 - (c) If, during the Run-Out Period, Run-Out Amounts Billed exceed the Specific Attachment Point and the Aggregating Specific Deductible indicated in Item B.4., if applicable, of the Exhibit, such excess, if any, shall be referred to in this Policy as Run-Out Stop-Loss Claims and the coverage provided hereunder for such claims as Run-Out Stop-Loss Insurance.
 - (d) If, during the current Policy Period, aggregate Amounts Billed less Specific Stop-Loss Claims, if any, exceed 1) the Aggregate Attachment Point and 2) Minimum Aggregate Attachment Point indicated in Item A.4. of the Exhibit to the Policy, such excess, if any, shall be referred to in this Policy as Aggregate Stop-Loss Claims.
 - (e) Stop-Loss Claims may also include claims paid by the Policyholder's prior claim administrator as specified on the Exhibit.
30. **“Stop-Loss Premium”** means the Monthly or annual premium, calculated by multiplying the number of Coverage Units for a particular Month by the premium rate indicated in Items A.5. and/or B.5. of the Exhibit, that is required by the Company for the risk assumed under the Policy as indicated in Item A.1. and/or B.1. of the Exhibit. The Policyholder shall pay to the Company the Stop-Loss Premium by the date set forth on the Stop-Loss Premium invoice. If the Policyholder's payment is more than one business day late, the Policyholder shall pay a late fee in the amount as described in this Policy.

The Stop-Loss Premium shall be subject to change by the Company (and the Aggregate Stop-Loss Attachment Point revised retroactive to the first month of the Contract Year) upon the occurrence of any of the following:

- (a) Any changes or benefit variances in the Policyholder's Plan, its administration, or the level of benefit valuation which would increase the Company's risk;
- (b) Changes imposed by governmental entities, including taxes and fees, increase expenses incurred by the Company provided that such increases shall be limited to an amount sufficient to recover such increase in expenses; or

- (c) Company determines that there has been a change in Coverages or the number of Coverage Units has changed by an amount equal to 10% or more of total enrollment from the number shown in Items A.6. and/or B.6. of the Exhibit.

Any Stop-Loss Premium changes will be effective beginning on the first day of the first full month following thirty (30) day notification by Company to Policyholder.

SECTION II POLICY PROVISIONS

1. **STOP-LOSS CREDIT.** The Company hereby agrees to credit the Policyholder as specified in the section of this Policy entitled SETTLEMENTS against the Amounts Billed during the Policy Period which are in excess of the Aggregate Attachment Point or Specific Attachment Point. If the Policyholder selects an Aggregating Specific Deductible as part of its Policy, in addition to the Specific Attachment Point, a deductible of amount specified in Item B.4. in Amounts Billed must be met before any credit is made by the Company. This additional deductible amount may be met on behalf of one or more Enrollees and must be an accumulation of Amounts Billed in excess of those applied to the Specific Attachment Point within the Policy Period. The Company shall not be liable for, nor shall the credit be extended to, any claim or liability for extra-contractual, compensatory, or punitive damages, including interest, statutory penalties and attorney fees or any payments made as an exception to the Plan. Unless otherwise specified in the Exhibit, the Company shall not be liable for the cost of administration of a Plan, including any costs related to investigation, payment or other services provided by a third-party administrator or any other party.
2. **ENTIRETY.** This Policy, the Exhibit, and any attachments shall constitute the entire Policy between the parties for the purposes of this Policy and shall supersede any and all prior or contemporaneous Policies or understandings, either oral or in writing, between the parties with respect to the subject matter herein. This Policy shall not create any right or legal obligation between the Company and any Enrollee under the Plan.
3. **MODIFICATION.** Except for the Exhibit to this Policy, which may be changed at any time in accordance with the provisions of this Policy by notifying the Policyholder in writing of such change, no modification, amendment, change, or waiver of any provision of this Policy shall be valid unless agreed to by an officer of Company and an authorized representative of the Policyholder.

SECTION III PREMIUM PROVISIONS

1. **PREMIUM PAYMENT.** The premium amounts to be paid to the Company as consideration for the insurance provided hereunder shall be specified on the Exhibit and the method of payment shall be set forth in the Contract.
2. **REMITTANCE.** The Company shall bill the Policyholder for the Stop-Loss Premium amount due and the Policyholder shall remit payment as set forth in the Contract. A remittance will be considered received when actually delivered into the possession or control of the Company.
3. **LATE FEE.** A late fee shall be assessed for the late remittance of any amount(s) due and payable to the Company by the Policyholder. This charge shall be an amount equal to the lesser of:
 - (a) 2.0% of any outstanding amount due; or
 - (b) The maximum rate permitted by state law.

4. **NOTICE, SUBROGATION, AND PROOF OF LOSS.** The Company shall reimburse the Policyholder as specified in the section of this Policy entitled SETTLEMENTS. Payment to the Policyholder in settlement of claims hereunder shall not be construed as a waiver of, or prohibition against, the Company's right to adjudicate or make further adjustments to such settlements. The subrogation provisions of the Contract are hereby incorporated by reference except to the extent they conflict with a specific provision of this Policy.

No action at law or in equity shall be brought to recover on this Policy more than three (3) years from the date of Termination of the Policy regardless of any "Run-Out" Coverage.

If any time limitation of this section of the Policy is less than that permitted by the state of Michigan at the time this Policy is issued, such limitation is hereby extended to agree with the minimum permitted by such law.

The books and records of the Policyholder which pertain to the Plan, including any Proof of Loss required by the Plan, shall be open to the Company and its representatives at all times during the usual business hours for inspection.

5. **RUN-OUT STOP-LOSS PREMIUM.** If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Coverage and only if selected at least twelve months prior to termination of the Contract), the Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for the final month before termination by the Specific Stop-Loss Premium amount indicated in Item B.5. and shall be payable for the first three months after termination of the Contract. However, if the number of Coverage Units in the final month is less than the number in the month exactly one year earlier, BCBSM shall calculate the Monthly Premium using the higher count from one year earlier.

SECTION IV SETTLEMENTS

1. **SPECIFIC STOP-LOSS SETTLEMENT.** The invoices or payment schedules provided under the Contract shall include the premium due under this Policy as well as any credits to the Policyholder for Specific Stop-Loss Claims existing at that time. To the extent that a true-up is needed to reflect corrections or adjustments based on the actual number of Employees covered at any one-time during Policy Period or for other reasons, including but not limited to recovery of claims, the Company will provide, within 120 days after the end of each Policy Period during which this Policy is in effect, an annual settlement. Any deficit or surplus resulting from this settlement will be reflected in a subsequent bill. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.

If this Policy is terminated prior to the expiration of the Policy Period, claim settlements for Specific Stop-Loss Claims will be made, as specified herein, for only those full Months of the Policy Period immediately preceding Policy termination. Specific Stop-Loss Coverage shall not extend beyond the termination date of this Policy.

2. **AGGREGATE STOP-LOSS SETTLEMENT.** For any Aggregate Stop-Loss Claims, the claim settlement shall be provided to the Policyholder by the Company within 120 days after the end of each Policy Period during which this Policy is in effect. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.
3. **RUN-OUT PERIOD SETTLEMENT.** If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Insurance and only if selected at least twelve months prior to termination of the Policy), credits shall be provided to the Policyholder for Run-Out Stop-Loss Claims under this Policy as part of the Run-Out process under the Policy. Within 120 days following the Run-Out Period, the Company shall prepare a settlement statement that will include a final reconciliation of all Run-Out Stop-Loss Claims.

SECTION V

GENERAL PROVISIONS

1. **TERMINATION.** This Policy will terminate upon the earliest of the following dates:
 - (a) The end of the Policy Period.
 - (b) The date specified in writing by the Policyholder provided that Company is notified at least 30 days in advance of the termination date.
 - (c) The date mutually agreed to in writing by both parties.
 - (d) The date specified in writing by Company following Policyholder's failure to timely pay amounts due provided that Policyholder is notified at least 5 days in advance of the termination and during which Policyholder's delinquency is not cured.
 - (e) The date the Plan terminates.
 - (f) The date the Contract terminates.

In the event of termination of this Policy for any reason prior to the expiration of a Policy Period, no Aggregate Stop-Loss Coverage will exist for the Final Policy Period or Run-Out Period. The Policyholder will be required to fund all claims during the Final Policy Period and Run-Out Period. The Company shall have no obligation to determine a Claim settlement for the period during which coverage was not in effect nor shall the Company refund any portion of the premium(s) to the Policyholder.

2. **ADVISORS.** Each party acknowledges that it has had full opportunity to consult with such legal and financial advisors as it has deemed necessary or advisable in connection with its decision knowingly to enter into this Policy. Neither party has executed this Policy in reliance on any representations, warranties, nor statements made by the other party hereto other than those expressly set forth herein.
3. **ASSIGNMENT.** No part of this Policy, or any rights, duties, or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Company's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel from other parties shall not constitute an assignment under this Policy.
4. **GOVERNING LAW.** This Policy shall be governed by, and shall be construed in accordance with, the laws of the State of Michigan without regard to any state choice-of-law statutes, and any applicable federal law.
5. **INSOLVENCY.** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Enrollees under a Plan.

6. **LIABILITY.** The Company will have neither the right nor the obligation under this Policy (though such right or obligation may exist under the separate Contract) to directly pay any Enrollee or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit an Enrollee to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to it by reason of this Policy.
7. **NO WAIVER.** The failure of either the Policyholder or the Company to insist upon strict performance of any of the terms of this Policy shall not be construed as a waiver of its respective rights or remedies with respect to any subsequent breach or default in any of the terms of this Policy.
8. **NOTICES.** Unless otherwise provided in this Policy, any notice required shall be given in writing and sent to the other party either by hand-delivery, electronic message to a designated representative of the other party, or postage-pre-paid U.S. first-class mail at the following address or such other address as a party may designate from time to time:
- If to Policyholder: to the Policyholder's address as shown in the Contract
- If to the Company: Blue Cross Blue Shield of Michigan
600 Lafayette East, Mail Code B612
Detroit, Michigan 48226-2998
9. **OFFSET.** Policyholder must promptly refund any erroneous reimbursement or credit issued by Company upon notice to Policyholder of such error. To the extent Policyholder fails to make such refund, Company may deduct the amount erroneously credited from any future reimbursement or credit owed to Policyholder.
10. **SERVICE MARK LICENSEE STATUS.** The Company is an independent licensee of BCBSA and is licensed to use the "Blue Cross" and "Blue Shield" names and service marks in Michigan. The Company is not an agent of BCBSA and, by entering into this Policy, Policyholder agrees that it did so based solely on its relationship with the Company or its agents. Policyholder agrees that BCBSA is not a party to this Policy, has no obligations under this Policy, and that no BCBSA obligations are created or implied under this Policy.
11. **SEVERABILITY.** In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Policy, but this Policy shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

EXHIBIT TO THE STOP-LOSS COVERAGE POLICY

Policyholder: **COUNTY OF ST CLAIR**

Customer ID: **130983** Policy Period: **01/01/2022** through **12/31/2022**

The specifications below shall become effective on the first day of the Policy Period specified above and shall continue in full force and effect until the earliest of the following: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Exhibit is superseded in whole or in part by a later executed Exhibit.

A. AGGREGATE STOP-LOSS INSURANCE

Group did not purchase Aggregate Stop-Loss Insurance.

B. SPECIFIC STOP-LOSS INSURANCE

1. Claims Covered	Renewal of Existing Coverage: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.
2. Lines of Business Covered	Medical Claims and Prescription Drug Claims covered by Stop-Loss Policy
3. Specific Attachment Point (per Coverage Unit)	\$160,000.00
4. Aggregating Specific Deductible	[N/A]
5. Monthly Premium (per Coverage Unit)	\$143.79
6. Number of Coverage Units	663
7. Run-Out Coverage	Group may elect "Run-Out" Coverage by checking the "Yes" box on the Group Signature Page. Unless checked "Yes", Group will not have Stop-Loss Run-Out coverage. "Run-Out" Coverage applies to claims incurred on or after the Original Effective Date of Policy and paid during the Run-Out Period

C. ADDITIONAL PROVISIONS TO SPECIFIC STOP-LOSS INSURANCE

SECOND YEAR RATE CAP & NO-NEW LASER

The Company will not change the Specific Premium rate in Item B.5 for the Second Year Policy Period by more than the percentage noted, as long as the coverage details in Items B.2, B.3, and B.4 remain the same per Coverage Unit. The Company will not apply additional lasers in the Second Year Policy Period, referenced in this Section.

Rate Cap:

50%

**Second Year
Policy Period:**

01/01/2023

through

12/31/2023

Deltal Dental Contract Renewal

Summary:

ATTACHMENTS:

	Description	Upload Date	Type
📎	TDelia Memo to Board Re BCBS-Dental Renewal 2022 PY	11/22/2021	Cover Memo
📎	St Clair County- Group 3636-0099 Contract eff 1-1-2022 (3 Yrs)	11/22/2021	Cover Memo
📎	St Clair County- Group 3636-2000 Contract eff 1-1-2022 (3 Yrs)	11/22/2021	Cover Memo
📎	St Clair County- Group 3636-3000 Contract eff 1-1-2022 (3 Yrs)	11/22/2021	Cover Memo



COUNTY OF ST. CLAIR

HUMAN RESOURCES DEPARTMENT



DIANE BARBOUR
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STEPHANIE FRIZZLE
HR Generalist
sfrizzle@stclaircounty.org
Ext. 6202

To: St. Clair County Board of Commissioners

From: Tina Delia, Sr. HR Specialist

Date: November 19, 2021

Subject: Blue Cross Blue Shield & Delta Dental Annual Renewal

The attached Blue Cross Blue Shield Schedule A Renewal and Stop Loss Exhibit reflects the administrative and stop loss fees to be paid per contract per month for employees and non-Medicare eligible retirees for the 2022 plan year. The administrative fee is increasing by 3% and the stop loss fee is increasing by 9.3%. However, this increase in fees will be offset by favorable claims experience and the 2022 prescription drug rebates estimated at \$679,000. All of these changes have been factored into the employee premium share calculation for 2022, resulting in a minimal increase of less than 0.3% for employees.

The stop loss level for 2022 will remain at \$160,000 and includes coverage for medical and prescription drug claims.

The attached Delta Dental renewal includes a three year rate hold at our current administrative fee of \$4.07 per month per contract for employees and retirees.

RECOMMENDATION: Human Resources recommends that the Board of Commissioners approve the Blue Cross Blue Shield and Delta Dental 2022 renewal documents as presented.

OFFICE ADDRESS:
200 Grand River Ave.
Suite 206
Port Huron, MI 48060
Phone: 810-989-6910
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www.stclaircounty.org



Delta Dental Service Contract For St. Clair County

This Service Contract ("Contract") is entered into by and between St. Clair County (the "Contractor") and Delta Dental Plan of Michigan, Inc., a Michigan non-profit corporation ("Delta Dental"). Delta Dental agrees to perform claims administration services for the Contractor's self-funded dental benefit plan. Contractor and Delta Dental may be singularly referred to herein as "Party" and collectively referred to herein as the "Parties". This is a legally binding contract between the Contractor and Delta Dental and is effective on January 1, 2022, the ("Effective Date").

SECTION I - DECLARATIONS

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

- A. Effective Date:** 12:01 A.M. Standard Time, January 1, 2022
- B. First Renewal Date:** January 1, 2025
- C. Client Number:** 3636-0099, 1000
- D. Rate(s):**
See Addendum
- E. Performance Guarantee(s):** See Addendum

DELTA DENTAL PLAN OF MICHIGAN, INC.

BY:

President and CEO

DATE: October 8, 2021

CONTRACTOR

BY:

(Authorized Signature)

(Title)

BY:

(Witnessed By)

(Title)

DATE:

ADDENDUM

St. Clair County
3636-0099, 1000
January 1, 2022

D. Rate(s):

Administrative Service Fee: Composite - \$4.07 per month per Enrollee

This rate is contingent upon the enrollment of a minimum of 75 percent of the eligible members of the defined group and their eligible dependents. In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for Cost of Claims for the preceding month on the first (1st) of each month. Payment shall be due on or before the twentieth (20th) of that month. Rates do not include any applicable claims taxes.

The total deposit held by Delta Dental for this Contractor will be \$57,000.00.

E. Performance Guarantee(s):

The following Performance Guarantees have been agreed to by both parties.

In the event this Agreement is terminated by either party before its First Renewal Date, these Performance Guarantees are null and void. These Performance Guarantees will only be tracked, reported, and paid on a calendar-year basis for each full calendar year that this Agreement is in effect. In addition, if Delta Dental's performance meets or exceeds the guaranteed performance for three consecutive years, Delta Dental will have no further liability for tracking, reporting, or refunding administration costs for Performance Guarantees.

The total refund in any calendar year will not exceed 50 percent of Contractor's total annual administration costs. Total annual administration costs equal the annual exposure multiplied by the per Subscriber administration cost, excluding commissions, if payable.

1. Turnaround Time Guarantee

Delta Dental guarantees to process 95 percent of all dental claims for all Contractors within ten business days (measured from the date a completed claim is received to the date it is adjudicated in the claim system or denied).

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent below the 95 percent goal.

2. No Balance Billing Guarantee

When Dentists sign contracts to participate with Delta Dental, they agree to accept Delta Dental's determination of payment as the full fee for covered services. If a Participating Dentist's Submitted Fee is higher than the amount that Delta Dental approves, they agree not to charge the difference to Subscribers (or "balance bill" Subscribers). Delta Dental guarantees Subscribers will never have to pay that difference.

If a Subscriber is balance billed by a Participating Dentist, Delta Dental guarantees to investigate each occurrence and, when appropriate, to make the Subscriber whole.

3. Telephone Average Speed of Answer Guarantee

Delta Dental guarantees that the annual average speed of answer of all calls to Delta Dental's customer service department will be 25 seconds or less.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each second above 25 seconds.

4. Telephone Abandonment Rate Guarantee

Delta Dental guarantees that the annual call abandonment rate for Delta Dental's customer service department (or the rate of callers who hang up before their call is answered) will be five percent or less.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent that the call abandonment rate exceeds the five percent goal.

5. Claims Financial Accuracy Guarantee

Delta Dental guarantees that the financial accuracy rate, measured as the total claim dollars paid correctly divided by the total claim dollars audited in a statistically valid sample from all claims paid from all groups, with errors including the absolute value of all overpayments and underpayments, will be at least 99 percent.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 99 percent goal.

6. Claims Payment Accuracy Guarantee

Delta Dental guarantees that the payment accuracy rate, measured as the number of claims paid correctly divided by the number of claims audited in a statistically valid sample from all claims paid from all groups, with errors including all overpayments, underpayments, and dollars paid to the wrong payee, will be at least 98 percent.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 98 percent goal.

7. Claims Processing Accuracy Guarantee

Delta Dental guarantees that the processing accuracy rate, measured as the number of correctly processed paid claims divided by the total number of claims audited in a statistically valid sample from all claims paid from all groups, will be at least 98 percent. The processing accuracy rate measures all types of errors, not just financial errors.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 98 percent goal.

8. Satisfactory Account Management Guarantee

Delta Dental guarantees that the Contractor will be satisfied with the management of the account.

If the Contractor is not completely satisfied with its account management each calendar year as indicated by a grade of B or above on Delta Dental's annual account management report card, Delta Dental will refund five percent of the Contractor's total annual administration costs.

9. Member Satisfaction Guarantee

Delta Dental guarantees that at least 95 percent of respondents to Delta Dental's standard member satisfaction survey will be satisfied with us as a whole.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent that the overall member satisfaction rate is below the 95 percent goal.

10. Panel Savings Guarantee

Delta Dental guarantees that the Contractor's annual savings from fee and policy reductions, as reported on the Contractor's annual Treatment Savings report, will be at least 13 percent.

This percentage will be calculated by dividing (a) the sum of Fees not Allowed Due to Processing Policies, Fee Reduction (both Member and Non-member Dentists), and Savings from Dental Consultant Review by (b) total charges less Invalid Claims and All Other Savings.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund any deficit where the Contractor's actual annual percentage as defined above is not at least 13 percent, up to a maximum of 25 percent of the Contractor's total annual administration costs.

SECTION II - DEFINITIONS

The following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent. Capitalized words and terms not defined below are defined in the Certificate.

ADMINISTRATIVE SERVICE FEE means the fee charged by Delta Dental® for the administrative services performed under this Contract.

BENEFIT MANAGER TOOLKIT means Delta Dental's online portal used for eligibility updates and Dental Plan information.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CONTRACT means this document, including the Certificate and applicable Summary(ies) of Dental Plan Benefits (the terms of which are incorporated herein), the materials submitted by the Contractor in applying for coverage, and, if applicable, any appendices, supplements, riders, successor agreements, renewal letters, or renewals now or hereafter issued or executed.

COST OF CLAIMS means the total amount of Claims payments made by Delta Dental for Covered Services for which the Contractor must reimburse Delta Dental.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

SECTION III - ERISA

Contractor, or a person designated by Contractor (other than Delta Dental), shall be the Named Fiduciary of the Contractor's Dental Plan as that term is defined by ERISA §402(a)(2). To the extent Contractor has delegated to Delta Dental the responsibility and discretionary authority to make final claims determinations, Delta Dental shall be the named fiduciary with respect to such determinations. Any determination or interpretation made by Delta Dental pursuant to this authority is binding on the Member and the Contractor unless it is demonstrated that the determination was arbitrary and capricious. In the event final claims determinations are made by any other entity, Delta Dental shall not be a fiduciary with respect to such determinations. Furthermore, to the extent that Delta Dental is deemed to possess any plan assets of the Dental Plan, Delta Dental will be a fiduciary with respect to such assets to the extent that Delta Dental exercises discretion and control over such assets. Except as otherwise stated herein, Delta Dental shall not have any further discretionary authority or control respecting the management of the Dental Plan or the Dental Plan's assets, if any, and the Contractor retains all responsibility and authority, including all other fiduciary responsibilities, as defined in ERISA, for operation of the Dental Plan.

SECTION IV - ELIGIBILITY AND ENROLLMENT

- A. Contractor shall have sole responsibility for determining the eligibility of, and shall manage the enrollment, disenrollment, and contribution obligations of all Members.
- B. As a condition of enrollment, the Contractor shall require all Members to provide Delta Dental with all information needed to process claims and administer Benefits. Such information may include, but not be limited to, the Member's dental records. In the event a Member fails and/or refuses to provide Delta Dental with requested information, Delta Dental may place the Member's coverage on hold.
- C. Contractor shall provide Delta Dental with an initial eligibility upload of all Members. Such eligibility upload shall be in a form and format acceptable to Delta Dental. Thereafter, Contractor shall provide Delta Dental with eligibility updates on an as needed basis, which in no event shall be less than monthly. Contractor shall promptly respond to any requests for information made by Delta Dental concerning the eligibility of a Member.
- D. Contractor shall be solely responsible for the accuracy and delivery of all eligibility information submitted to Delta Dental. Delta Dental shall not be liable for any losses or damages resulting from eligibility information provided by Contractor and/or any other third party.
- E. Unless otherwise stated in the Declarations Section of this Contract, no retroactive eligibility updates will be accepted for an effective date more than six months from the date of notification. If the Contractor requests that a Enrollee's eligibility be terminated retroactively and a claim was incurred for that Enrollee or that Enrollee's Dependent after the requested termination date, the Enrollee's eligibility will continue until the end of the month in which the claim occurred, and Contractor shall be responsible for all Cost of Claims and applicable Administrative Service fees for services that were rendered to the Enrollee or Dependent up until the effective termination date. In addition, in the event that an Enrollee or Dependent is retroactively added, Contractor shall be responsible for all Cost of Claims and applicable Administrative Service fees for services that were rendered to the Enrollee or Dependent from the effective addition date forward.
- F. Upon reasonable prior written notice, Delta Dental shall have the right to audit the accuracy of Contractor's eligibility information. Contractor's refusal to permit such audit shall be deemed a material breach of this Contract.

- G. Contractor shall be solely responsible for identifying Members entitled to COBRA continuation benefits. Contractor shall provide all required notices, collect all necessary payments, and otherwise administer all facets of its COBRA program. In the event that Contractor continues to provide eligibility information to Delta Dental for a Member during the COBRA election period, as opposed to terminating coverage and then retroactively reinstating a Member upon the Member's election of COBRA coverage, Contractor shall be liable for any Claim paid during that period if the Member ultimately does not elect COBRA coverage.
- H. In the event that a Member undergoes a change in eligibility, Contractor must notify Delta Dental of such change. Any failure by Contractor to provide timely notice of eligibility changes may result in Benefits being improperly administered. Contractor shall be solely responsible for such failures. Contractor must notify Delta Dental immediately for any change in a Member's eligibility. In the event Contractor does not notify Delta Dental immediately, Contractor shall be responsible for any paid Claims.
- I. If the Contractor elects to transmit eligibility information via the Benefit Manager Toolkit, Contractor shall execute all proper authorization forms prior to accessing Delta Dental's systems.
- J. Delta Dental will deliver to the Contractor an electronic copy of the Certificate for distribution to each Enrollee, unless otherwise agreed to in writing by the Parties.
- K. The Contractor will timely distribute to each of its Enrollees the Certificates and other information provided by Delta Dental regarding the Benefits available under this Contract, unless otherwise agreed to in writing by the Parties.
- L. Delta Dental shall furnish the Contractor with enrollment forms and related informational materials necessary and appropriate to enroll the Contractor's Members. Delta Dental shall provide reasonable assistance to Contractor on an as needed basis during the enrollment process.
- M. In the event of any material changes in enrollment or composition of Members or if invoices are not paid as billed, unless otherwise agreed to in writing, Delta Dental shall have the right in its sole discretion to either:
1. Terminate this Contract pursuant to Section IX; or
 2. Propose an adjustment to the Administrative Service Fee. If the proposed adjustment to the Administrative Service Fee is not accepted by Contractor within 30 days of receipt of the proposed adjustment, Delta Dental reserves the right to terminate this Contract.

SECTION V - COVERED SERVICES

- A. Delta Dental shall administer and make payment for Covered Services in accordance with this Contract and the Certificate attached hereto. Contractor may request changes to the Covered Services available to Members by submitting the request in writing to Delta Dental. Changes to Covered Services are subject to Delta Dental's approval and may cause an increase to the Administrative Service Fee. Any changes to Covered Services must be agreed to in writing by Delta Dental prior to implementation. Contractor shall be responsible for determining all potential tax consequences relating to the covered benefits it selects.

SECTION VI - DELTA DENTAL NETWORK

- A. Delta Dental shall provide Members with an established network of dentists ("Participating Dentists") who have agreed to accept Delta Dental's Maximum Approved Fees for Covered Services. Delta Dental has complete discretion when setting the Maximum Approved Fees. For a detailed description of how payment is made, see Section VI of the applicable Certificate.
- B. Delta Dental shall ensure that there are an adequate number of qualified and credentialed Participating Dentists.
- C. Delta Dental is under no obligation to contract with any particular dentist and/or maintain any particular Participating Dentist in its network. In addition, Delta Dental is under no obligation to recommend or refer any dentist to a Member.
- D. Contractor acknowledges and agrees that:
1. Delta Dental does not provide, direct, or control the provision of dental services to Members.
 2. All decisions regarding dental services are made solely by the Member and his or her dentist; and
 3. Delta Dental does not warrant or guarantee that the dental services received by a Member from his or her dentist will be rendered in accordance with generally accepted standards or procedures.

SECTION VII - CLAIMS AND APPEALS

- A. Delta Dental will adjudicate and process all clean Claims submitted for Contractor's Dental Plan, in accordance with this Contract, the Certificate and Delta Dental's standard operating procedures. Clean Claims are those Claims that contain all information necessary for Delta Dental to process the Claim. In the event that Delta Dental does not receive a clean Claim, the Claim will be denied and will not be chargeable to the Member if the services were rendered by a Participating Dentist.

- B. Subject to the terms of this Contract and unless otherwise stated in the Declarations Section of this Contract, Delta Dental has complete discretion to process Claims received under Contractor's Dental Plan. As such, Delta Dental shall, without limitation, make determinations regarding:
1. Coordination of benefits;
 2. The applicability of Benefit waiting periods, limitations and exclusions; and
 3. The quality of care provided to Members by a treating dentist.
- C. Delta Dental shall provide Pre-Treatment Estimates to Members and Participating Dentists upon request as set forth in the Certificate. A Pre-Treatment Estimate is a voluntary and optional process where Delta Dental issues a written estimate of Benefits that may be available under the Dental Plan. A Pre-Treatment Estimate is not a prerequisite or condition for approval of future Benefits payment. Receipt of a Pre-Treatment Estimate does not guarantee payment or coverage, and is not a formal adjudication of a Claim. Pre-Treatment Estimates do not assess whether a Member is specifically eligible for a Covered Service or whether he or she has reached any applicable annual or lifetime maximum payments under the Dental Plan.
- D. Delta Dental will follow established procedures for resolving all adverse Claims determination questions asserted by a dentist or Member as set forth in the Certificate ("Claims Appeal Procedure"). The Claims Appeal Procedure shall contain processes for appealing initial adverse determinations made by Delta Dental. To the extent the Dental Plan is governed by ERISA, Delta Dental's procedures shall comply with ERISA and any regulations or guidelines thereunder. All determinations made according to the Claims Appeal Procedure will be final and binding on the Participating Dentist and the Member, unless otherwise stated in the Declarations Section of this Contract; provided, however, that the Member may exercise any additional legal rights he or she may have.
- E. Payments made directly to a Member as reimbursement for Covered Services under the Dental Plan are for the personal benefit of such Member and cannot be transferred or assigned unless otherwise stated in the Declarations Section of this Contract. Delta Dental shall not honor attempts to assign Benefits unless required by law.
- F. Delta Dental shall use reasonable efforts to recover any overpayments on Contractor's behalf. Delta Dental is under no obligation to engage in litigation in an attempt to recover such payments. Any funds recovered by Delta Dental will be properly credited to Contractor. Notwithstanding the foregoing, Delta Dental will be responsible for any overpayments made due to Delta Dental's negligence or breach of this Contract.
- G. Delta Dental does not insure or underwrite risk for Claims submitted on behalf of Members. The Contractor retains sole responsibility for all Claims properly paid by Delta Dental under this Contract.

SECTION VIII - PAYMENT

- A. The Contractor agrees to reimburse Delta Dental for the actual Cost of Claims and the invoiced Administrative Service Fee as set forth in the Declarations Section of this Contract. Delta Dental shall not be obligated to accept partial or late payments and acceptance of a partial or late payment will not waive Delta Dental's remedies under this Contract, or otherwise modify the terms herein.
- B. The Contractor shall maintain funds necessary to satisfy its obligations under this Contract.
- C. Unless otherwise stated in the Declarations Section of this Contract, payment for Administrative Service Fees shall be due on the fifth of each month. An invoice for the current month's Administrative Service Fees shall be sent on or about the third week of the preceding month.
- D. The Contractor is responsible for the full amount of all invoices regardless of any contribution owed by the Members to the Contractor. Delta Dental shall not be responsible for collecting any contributions from Members.
- E. If required by Delta Dental, Contractor shall deposit an amount specified in the Declarations Section of this Contract ("Prefund") with Delta Dental. The Prefund shall serve as a deposit to offset against any untimely or partial payments from Contractor. In the event Delta Dental uses any of the Prefund to offset untimely or partial payments, Delta Dental shall submit an invoice to the Contractor in the amount necessary to replenish the Prefund. If the Contractor fails to timely replenish the Prefund, Delta Dental shall be entitled to all remedies set forth in Section XI.

SECTION IX - TERM AND TERMINATION

- A. This Contract shall remain in full force and effect for the initial term commencing on the Effective Date and continuing until the First Renewal Date, as specified in the Declarations Section. Thereafter, the Contract may be renewed for subsequent terms as specified in the Declarations Section or in a renewal letter, unless Contractor or Delta Dental provides written notice of its intent not to renew at least thirty (30) days prior to the expiration of the then current term.

- B. In the event of a Party's material breach, the non-breaching Party may terminate this Contract by sending written notice to the breaching Party explaining in detail the nature of the breach and providing an opportunity to cure, which in no event shall be less than 30 days. In the event the material breach is not cured within the notice period, the non-breaching party may immediately terminate this Contract.
- C. Unless otherwise stated in the Declarations Section of this Contract, this Contract may be terminated by either Party without cause upon 60 days written notice to the other Party.
- D. There shall be a twelve month run-out period for all Claims incurred prior to the termination date, except in cases where Delta Dental has terminated this Contract for cause. All Claims paid by Delta Dental during this run-out period shall be invoiced to the Contractor in accordance with Section VIII of this Contract. Any Claims for services rendered after the termination date shall be denied. After the conclusion of the twelve month run out period, Claims shall be denied and Delta Dental shall not have any further obligations to the Contractor.
- E. Following the Claims run-out period, Delta Dental shall prepare a final settlement statement and invoice for Contractor. Such settlement statement and invoice shall detail the final amounts due and owing between the Parties including, to the extent applicable, any remaining Prefund deposited by the Contractor, all outstanding Administrative Service Fees and all remaining Claims payments made during the run-out period.
- F. Any false or misleading statements made by either Party shall be considered a material breach of this Contract.

SECTION X - CONFIDENTIALITY AND DISCLOSURE

- A. The Parties have entered into a Business Associate Agreement regarding the permissible use and disclosure of Member's protected health information as that term is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all subsequent amendments thereto. The Business Associate Agreement is attached as an Addendum hereto.
- B. The Parties acknowledge that in the course of performing under this Contract each Party may be provided with or given access to information, in oral, recorded or written form, that is proprietary and confidential to the other Party (collectively referred to as the "Confidential Information"). Such Confidential Information includes, but is not limited to: information regarding the other Party's management, business, organizational structure, policies, procedures, business relationships, intellectual property, copyrights, patents, trademarks, software, data, databases, system designs, specifications, documentation, code, architecture, structure, algorithms, techniques, processes, protocols, product materials, notes, slides, ideas, Maximum Approved Fees, Allowed Amounts, preferred provider reports, actuarial formulas, providers' personal information, and financial terms of this Contract.
- C. Confidential Information shall not include any information that:
 - 1. Is already known to the Party at the time of the disclosure (as evidenced by written documentation existing at that time);
 - 2. Is generally available to the public or becomes publicly known through no wrongful act of a Party; or
 - 3. Is received by a Party from a third-party who had a legal right to provide it (as evidenced by written documentation existing at that time).
- D. The Parties each will make all reasonable, necessary and appropriate efforts to safeguard each other's Confidential Information. Each Party will safeguard the other's Confidential Information to the same extent that it safeguards information relating to its own business, which in no event will be less than the safeguards that a reasonably prudent business would exercise under similar circumstances.
- E. Each Party agrees not to use, distribute or exploit each other's Confidential Information, in whole or in part, for its own benefit or that of any third party and will not disclose such Confidential Information to any other person or entity without each other's prior written consent. A Party shall be responsible for any breach of this Contract by its employees, authorized subcontractors, agents or representatives.
- F. Notwithstanding anything to the contrary in this Section, the Parties shall be permitted to disclose Confidential Information as required by order of a court of law, administrative agency, or other governmental body; provided, however, the Party shall provide reasonable advance written notice to the other Party to the extent allowed by law in order to allow that Party the opportunity to seek a protective order or otherwise limit such disclosure, and the disclosing Party shall reasonably cooperate with the other Party to limit any such disclosure or to seek a protective order. If a Party is nonetheless required to disclose the other Party's Confidential Information, said Party shall only disclose the minimum information necessary to respond to the legal request. Notwithstanding the foregoing, Delta Dental shall not be required to provide Contractor notice prior to responding to governmental agency subpoenas regarding potential provider fraud or abuse.

SECTION XI - RIGHTS AND REMEDIES

- A. In addition to the right of termination described in Section IX, Delta Dental shall have the following rights and remedies in the event Contractor fails to timely pay in full the Administrative Service Fees or reimburse Delta Dental for the Cost of Claims, subject to Contractor's right to cure pursuant to Section IX.B.:
 - 1. Delta Dental may retroactively terminate this Contract to the date it last received payment; and

2. Delta Dental may initiate proceedings to recover and collect all payments due and owing, as well as all costs associated with the collection proceedings including, but not limited to, attorneys' fees.
 3. Notwithstanding the foregoing, Delta Dental may immediately suspend payment of all Claims in the event that it does not receive timely payment of the Administrative Service Fees or reimbursement for the Cost of Claims.
- B. No claim, lawsuit or action, may be brought more than three years after the claim first arose.
- C. Either Party's failure to exercise any right or remedy contained herein shall not constitute a waiver of any future rights or remedies available to that Party.

SECTION XII - GENERAL PROVISIONS

- A. **Subrogation.** Delta Dental shall be subrogated to all of Contractor's rights with respect to any Claim(s). However, Delta Dental is not obligated to institute or become involved in any litigation concerning such Claim(s). If after six (6) months Delta Dental is unable recover through reasonable efforts, using its standard overpayment recovery processes, any amounts due and owing to Contractor, Delta Dental will provide Contractor with notice of any such unrecovered Claims. The decision to further pursue recovery of such Claims shall be within the sole discretion of Contractor and at Contractor's sole expense. Delta Dental will provide reasonable assistance to Contractor in any such recovery efforts, but in no event will Delta Dental be obligated to undertake any recovery litigation unless mutually agreed to by Delta Dental and Contractor. Delta Dental will remit to Contractor any applicable funds recovered from third parties, less any expenses it has incurred in its recovery efforts. Such funds shall be applied as a credit to Contractor's invoice(s). Contractor will assist Delta Dental as will be reasonably necessary for Delta Dental to carry out its duties under this provision. Delta Dental may assign or subcontract a portion of its duties under this provision of the Contract to others.
- B. **Right to Review Published Materials.** Contractor agrees not to publish or distribute any materials containing the logo, trademark, or business mark of Delta Dental, or containing a change in the benefits to be administered under this Contract, until Delta Dental reviews and, with respect to the use of Delta Dental's logo, trademark, or business mark, approves the materials. This provision does not apply to materials that Delta Dental has provided to Contractor for distribution.
- C. **Cooperation.** The Contractor shall provide Delta Dental with any information it may reasonably require to administer the Dental Plan or otherwise discharge its duties under this Contract.
- D. **Indemnification.**
1. Each Party agrees to defend, indemnify, and hold harmless the other Party and its directors, officers, affiliates, agents, and employees (who are acting in the course of their employment, but not as claimants) from any loss, cost, or expense (including reasonable attorney fees and court costs) ("Losses") resulting from or arising out of or in connection with the indemnifying Party's breach of this Contract, or any negligent act or omission of any of the indemnifying Party's directors, officers, agents or employees, unless liability for such act or omission is expressly assigned elsewhere in this Contract.
 2. The indemnifying Party shall provide prompt written notice of relevant information concerning any Losses to the indemnified Party. Reasonable assistance (at the indemnifying Party's expense) may be requested by the indemnified Party in connection with the defense of any Losses. Notwithstanding the foregoing:
 - a. The indemnified party shall permit the indemnifying Party to control the defense or settlement of the claim, suit or proceeding at the indemnifying party's expense;
 - b. The indemnified Party shall have the right to provide for its separate defense at its own expense;
 - c. Neither Party shall settle any Losses without the consent of the other Party, which consent shall not be unreasonably withheld. Any release obtained as a result of settlement must contain a release of all claims against the indemnified Party as well as its officers, directors and employees, and
 - d. The indemnification obligations of indemnifying Party hereunder shall not extend to Losses attributable to the negligence, intentional misconduct, or willful malfeasance of the indemnified Party.
- E. **Notice.** Any notice required or permitted to be given under this Contract will be considered given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the other Party at its last address of record.
- F. **Survival.** The following Sections shall survive expiration or early termination of this Contract: Section VIII. Payment; Section X. Confidentiality & Disclosure; Section XI. Rights and Remedies; and Section XII. General Provisions.
- G. **Internal Policies and Procedures.** Delta Dental has the right to amend its internal policies and procedures periodically and without notice to the Contractor to the extent the amendment does not affect the delivery of

benefits to Members. Delta Dental will provide advance written notice, to the extent possible, to Contractor of any amendment to Delta Dental's policies or procedures that affect the delivery of benefits to Members; if advance notice is not possible, Delta Dental will provide written notice as soon as possible after the amendment is adopted.

- H. **Third Party Beneficiaries.** This Contract will not confer any rights or remedies on any third-party, other than the Parties to this Contract and their respective successors and permitted assigns.
- I. **Assignment and Subcontracting.** Unless it has first obtained the written consent of the other Party, neither Party may assign this Contract or any of its rights or obligations under this Contract to any other person, except that Delta Dental may make assignments to its subsidiaries and affiliates without the prior written consent of the Contractor.
- J. **Integration.** This Contract constitutes the entire understanding between the Parties with respect to the subject matter of this Contract and supersedes any prior discussions, negotiations, agreements and understandings.
- K. **Force Majeure.** Unless otherwise stated in the Declarations Section of this Contract, neither Delta Dental (including its agents, directors, officers, and employees) nor Contractor shall be liable for delays in performance due to circumstances beyond their reasonable control. Each Party shall be excused from performance under this Contract and shall have no liability to the other Party for any period during which it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other Party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications, and such nonperformance shall not be a default under or grounds for termination of this Contract.
- L. **Applicable Law.** This Contract and the obligations of the Parties under this Contract will be governed by and construed in accordance with ERISA to the extent applicable. If it is determined by a court of competent jurisdiction that ERISA does not apply, the law of the State of Michigan will control.
- M. **Venue.** The Parties submit to the jurisdiction and venue of the Circuit Court of Ingham County, State of Michigan, or if original jurisdiction can be established in the United States District Court of Western Michigan.
- N. **Severability.** If any part of this Contract or an amendment of it is found by an arbitrator, court, or other authority to be illegal, void or not enforceable, all other portions of this Contract shall remain in full force and effect.
- O. **Counterparts.** This Contract may be executed in one or more counterparts, each of which will be deemed an original agreement, but all of which will be considered one instrument and will become a binding agreement when one or more counterparts have been signed by each of the Parties and delivered to the other. Electronic and/or fax signatures shall be accepted as original signatures.
- P. **Audits.** The Contractor shall have the right to audit Delta Dental's files, books, and records (both paper and electronic) pertaining to the administrative services provided under this Agreement. The Contractor will bear the entire cost of any such audits. The Contractor may assign this right to audit to an agent, provided the agent is a licensed firm and the audit is led by an individual who holds a nationally recognized audit accreditation. Delta Dental will allow the Contractor or the Contractor's agent to audit the work areas at which services under this Contract are performed, within 14 business days of receipt of a fully-signed confidentiality agreement. Where applicable, Delta Dental agrees to segregate the Contractor's records from third-party records in order to allow accurate assessment of Contractor-specific processes. Such audits will take place no more than once in a 12-month period, unless both the Contractor and Delta Dental mutually agree that there is reasonable cause to conduct an audit more frequently, in which case the Contractor will give 14 business days' written notice before such audit. The scope of any audit conducted under this provision must be mutually agreed upon, in writing, by both parties prior to the start of the audit. Notwithstanding the foregoing, Contractor shall not have the right to audit any information which Delta Dental, in its sole discretion, determines is proprietary. During the audit, if claims samples are selected using a financially stratified methodology, the results shall be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.
- Q. **Other Goods and Services.** From time to time, Delta Dental may offer or provide Members certain goods and services, including discounts on dental services provided by Participating Dentists in addition to the dental coverage (including without limitation toothbrushes, dental floss and other oral hygienic devices/products). Delta Dental also may arrange for third party vendors to provide goods and services at a discount to Members. Though Delta Dental may make the arrangements, the third party vendors are solely liable for providing the goods and services. Delta Dental shall not be responsible for providing or failing to provide the goods and services to Members. Further, Delta Dental shall not be liable to Members for negligent provision of the goods and services by third party vendors. Delta Dental reserves the right to terminate or change these goods or services at any time.



**Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 3636-0099, 1000
St. Clair County**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan - Delta Dental of Michigan

Benefit Year - January 1 through December 31

Covered Services -

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Radiographs - X-rays	50%	50%	50%
Minor Restorative Services - fillings and crown repair	50%	50%	50%
Endodontic Services - root canals	50%	50%	50%
Periodontic Services - to treat gum disease	50%	50%	50%
Oral Surgery Services - extractions and dental surgery	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Other Basic Services - misc. services	50%	50%	50%
Relines and Repairs - to prosthetic appliances	50%	50%	50%
Major Services			
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable with no limitations.
- Space maintainers are payable once per area per lifetime for people age 15 and under.

- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per five-year period for first and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services except orthodontic services. \$1,500 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – None.

Waiting Period – Enrollees who are eligible for dental benefits are covered 30 days from date of hire.

Eligible People – All full-time employees of the county working at least 37.5 hours per week who choose the dental plan (1000) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0099).

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled. Also eligible is your domestic partner, as defined by the contractor.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the date of termination.

Delta Dental PPOTM

Our national PPO program

Welcome!

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan. Delta Dental of Michigan is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 800-524-0149 or access our website at www.DeltaDentalMI.com.

You can easily verify your own Benefit, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalMI.com and selecting the link for our Consumer Toolkit®. The Consumer Toolkit will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

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Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

I. Delta Dental PPO Certificate

Delta Dental Plan of Michigan, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Enrollee. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and the Contractor.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Goran M. Jurkovic, CPA, CGMA
President and CEO
Delta Dental Plan of Michigan, Inc.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

The amount permitted under the applicable fee schedule for This Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year

The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year, unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and the Contractor.

Child(ren)

Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim

A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- ◆ For dentures and partial dentures, on the delivery dates;
- ◆ For crowns and bridgework, on the permanent cementation date;
- ◆ For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment

The percentage of the charge, if any, that you must pay for Covered Services.

Contractor

The employer, organization, group, or association sponsoring This Plan.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Member Plan

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

Delta Dental Premier® Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Member Plan.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- ◆ **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
- ◆ **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
- ◆ **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.
- ◆ **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Delta Dental Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Delta Dental Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists."**

Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dependent(s)

Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits

Enrollee

You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Maximum Approved Fee

The Maximum Approved Fee is the lowest of:

- ◆ The Submitted Amount
- ◆ The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- ◆ The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Member(s)

Any Enrollee or Dependent with coverage under This Plan.

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period

The period of time, as determined by the Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate

A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Special Enrollment Period

A period outside of the Open Enrollment Period in which you or your Dependent can obtain coverage under This Plan due to a qualifying life event.

Spouse

Your legal spouse.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Members pursuant to this Certificate and your Summary of Dental Plan Benefits.

III. Enrolling in This Plan

The Open Enrollment Period, if applicable, will be established by the Contractor and will occur on an annual basis. During the Open Enrollment Period, all eligible persons as defined in your Summary of Dental Plan Benefits may enroll in This Plan. You and/or your Dependents may not enroll in This Plan at any other time during the applicable Benefit Year except in the following instances:

- a. Newly hired or rehired employees (if applicable): You will be eligible to enroll on the date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Dental Plan Benefits.
- b. New Spouse: Your new Spouse will be eligible to enroll on the date of marriage.
- c. Newborn: Your newborn will be eligible to enroll on the date of birth.
- d. Legal adoptions or guardianships: Your newly adopted Child(ren) and/or the minor Child(ren) that you and/or your Spouse have guardianship over will be eligible to enroll on the date that the legal petition for adoption or guardianship becomes legally final, or the date on which the Child(ren) begins residing with the Enrollee and the Enrollee assumes responsibility for the Child(ren) while waiting for adoption or guardianship to become final.
- e. New Stepchild: Your new stepchild will be eligible to enroll on the date that the Child's natural parent becomes a Dependent.
- f. To the extent Contractor permits Dependents other than those defined in this Certificate to enroll in This Plan, such Dependents will be eligible to enroll on the date that they become an eligible Dependent. Any such additional Dependents permitted by Contractor shall be set forth in your Summary of Dental Plan Benefits.
- g. All others will be permitted on the date that Delta Dental approves in

writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Dependent.

IV. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.DeltaDentalMI.com or call 800-524-0149.

V. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at 800-524-0149.
3. After you receive your dental treatment, you or the dental office staff will file a Claim form, completing the information portion with:
 - a. The Enrollee's full name and address
 - b. The Enrollee's Member ID number
 - c. The name and date of birth of the person receiving dental care
 - d. The Contractor's name and number

Notice of Claim Forms

Delta Dental does not require special Claim forms. However, most dental offices have Claim forms available. Participating Dentists will fill out and submit your dental Claims for you.

Mail Claims and completed information requests to:

**Delta Dental
P.O. Box 9085
Farmington Hills, Michigan 48333-9085**

Pre-Treatment Estimate

A Pre-Treatment Estimate is not required to receive payment, but it allows Claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a Claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under This Plan are post-service Claims. All Claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a Claim is filed, Delta Dental will adjudicate it within 30 days of receiving it. If there is not enough information to adjudicate your Claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the Claim, and (d) inform you or your Dentist that the information must be received within 45 days or your Claim will be Denied if the services were performed by a Nonparticipating Dentist, or not chargeable to the Member if the services were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to adjudicate your Claim. If you or your Dentist does not supply the requested information, Delta Dental will deny your Claim. In such case, you will be responsible for all charges if the services were performed by a Nonparticipating Dentist. If the services were performed by a Participating Dentist, the services will not be chargeable to the Member. Once Delta Dental adjudicates your Claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Contractor, call Delta Dental's Customer Service department, toll-free, at 800-524-0149, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to designate the person you wish to appoint as your representative. Delta Dental will only recognize the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to your Contractor or call Delta Dental's Customer Service department, toll-free, at 800-

524-0149. You may also write to Delta Dental's Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing to Delta Dental, please include your name, the Contractor's name and number, the Enrollee's Member ID number, and your daytime telephone number.

VI. How Payment is Made

Delta Dental shall make payments for Covered Services in accordance with the type of plan selected by the Contractor. The type of plan selected will be identified on your Summary of Dental Plan Benefits.

Delta Dental PPO (Point-of-Service)

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the Nonparticipating Dentist Fee for Covered Services.

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Delta Dental PPO (Standard)

Regardless of your Dentist's participating status, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. If your Dentist is not a PPO Dentist, but is a Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Orthodontics

If This Plan includes orthodontics it will be identified on and paid as reflected in your Summary of Dental Plan Benefits.

Covered Services Requiring Multiple Visits

In the event a Covered Service requires more than one (1) visit with your Dentist, payment for the Covered Service will be rendered upon Completion Date.

VII. Benefit Categories

The Benefits covered by This Plan are set forth in your Summary of Dental Plan Benefits.

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.

7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered under the terms of this Certificate.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract between Delta Dental and the Contractor.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision abutments, attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
42. Myofunctional therapy.
43. Mounted case analyses.
44. Antigen or antibody testing for a public health related pathogen.
45. Any and all taxes applicable to the services.

46. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Caries risk assessment performed on a Member age 2 or under.
5. Local anesthesia.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy as an aid to the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
27. Full mouth debridement, when done on the same day as comprehensive evaluation.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.

31. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
32. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
33. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
34. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
35. Capture only images which are not associated with any interpretation or reporting.
36. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
37. Implant removal when performed within three (3) months of an implant/mini-implant on the same tooth by the same dentist or dental office.
38. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.
6. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age 8 and under.
10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restoration on the same tooth are also subject to this five-year limitation.
11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
14. Hard full or partial arch occlusal guards are payable once in a lifetime.
15. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over.
16. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36 month period.
17. Prosthodontic Services limitations:
 - a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
 - b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - c. A removable unilateral partial denture is payable once per quadrant in any 5 year period unless the loss of additional teeth requires the construction of a new appliance.

- d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.
 - e. A relined or the complete replacement of denture base material is payable once in any three-year period per appliance.
 - f. Implant removal is payable once per lifetime per tooth or area.
 - g. Implant maintenance is payable once per any twelve (12) month period.
 - h. Removal of a broken implant retaining screw is payable once in a 5 year period.
18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:
- a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.
 - b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
 - c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.
20. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily

provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

- a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
 - b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
 - d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
 - e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
 - f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
 - h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
23. Maximum Payment:
- a. All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

25. Caries risk assessments are payable once in any 12-month period for Members age 3-18.
26. Assessments of salivary flow by measurement are payable once in any 36-month period.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
29. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five (5) applications per day.
30. Sealants are covered once per tooth per lifetime on first permanent molars for Members age 9 and under.
31. Sealants are covered once per lifetime on second permanent molars for members age 14 and under.
32. One cone beam CT is allowed within a twelve (12) month period except when performed for TMD treatment.
33. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a twelve (12) month period when done by the same dentist/dental office.
16. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same dentist/dental office.
17. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

IX. Coordination of Benefits

Coordination of Benefits (“COB”) applies to This Plan when a Member has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan’s Benefits are determined before or after another plan’s benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your Claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the Member to This Plan’s Enrollee, as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another plan that does not coordinate benefits, it will always be primary.

2. Enrollee v. Dependent Coverage

The plan that covers the Member as an Enrollee will be primary over a plan that covers the Member as a dependent. However, please note that if the Member is a Medicare beneficiary, federal law may reverse this order.

3. Children (Parents Divorced or Separated)

If a court decree makes one parent responsible for health care expenses, that parent’s plan is primary.

If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the Child’s health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

If neither of these rules applies, the order will be determined as follows:

- a. First, the plan of the parent with custody of the Child will be primary;
- b. Then, the plan of the spouse of the parent with custody of the Child will be primary;
- c. Next, the plan of the parent without custody of the Child will be primary; and
- d. Last, the plan of the spouse of the parent without custody of the Child will be primary.

4. Children and the Birthday Rule

The plan of the parent whose birthday is earliest in the calendar year is always primary for Children. For example, if your birthday is in

January and your spouse’s birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Laid Off or Retired Employees

The plan that covers the Member as a laid off or retired employee or as a dependent of a laid off or retired employee will be primary.

6. COBRA Coverage

The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA) will be primary.

7. Other Plans

If none of the rules above determines the order of benefits, the plan that has covered the Member for the longer period will be primary.

If the other plan does not have rule 5 and/or rule 6 (above) and decides the order of benefits differently from This Plan, This Plan may ignore either of those rules.

In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures for determining which plan is primary, unless prohibited by applicable law.

How Delta Dental Pays as Primary Plan

When Delta Dental is the primary plan, it will pay for Covered Services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan.

When Benefits are reduced as described above, each Benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person regarding the Claim being coordinated. Delta Dental need not tell or get the consent of any person to do this. Each person claiming Benefits

under This Plan must give Delta Dental any facts it needs to pay the Claim.

Facility of Payment

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

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

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, Delta Dental may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Member.

Payment includes the reasonable cash value of any benefits provided in the form of services.

X. Reconsideration and Claims Appeal Procedure

Reconsideration

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental’s Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you

can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

**Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916**

Please include your name and address, the Enrollee’s Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer’s decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person’s subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

XI. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- ◆ When the Contractor advises Delta Dental to terminate your coverage.
- ◆ On the first day of the month for which the Contractor has failed to pay Delta Dental.
- ◆ For fraud or misrepresentation in the submission of any Claim.
- ◆ For your Dependent, when they no longer qualify as a Dependent.
- ◆ For any other reason stated in the Contract between Delta Dental and the Contractor.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XII. Continuation of Coverage

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

1. Your employment, if applicable, ends for any reason other than your gross misconduct.
2. You do not qualify as an Enrollee as set forth in your Summary of Dental Plan Benefits.
3. You are divorced or legally separated.
4. You die.
5. Your Dependent is no longer a Dependent.
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XIII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide

payments or benefits for the Covered Services that were paid for by Delta Dental,

2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a Claim for such has not been received by

Delta Dental within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will deny that portion of the Claim that Delta Dental would have paid if the Claim had been timely submitted, and such denied portion of the Claim will not be chargeable to the Member. However, you will remain responsible for any applicable Deductible and/or Copayment. In the event that a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group Contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any

payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800-524-0147



Delta Dental Service Contract For St. Clair County

This Service Contract ("Contract") is entered into by and between St. Clair County (the "Contractor") and Delta Dental Plan of Michigan, Inc., a Michigan non-profit corporation ("Delta Dental"). Delta Dental agrees to perform claims administration services for the Contractor's self-funded dental benefit plan. Contractor and Delta Dental may be singularly referred to herein as "Party" and collectively referred to herein as the "Parties". This is a legally binding contract between the Contractor and Delta Dental and is effective on January 1, 2022, the ("Effective Date").

SECTION I - DECLARATIONS

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

A. Effective Date: 12:01 A.M. Standard Time, January 1, 2022

B. First Renewal Date: January 1, 2025

C. Client Number: 3636-2000, 2001, 2002

D. Rate(s):

Administrative Service Fee: Composite - \$4.07 per month per Enrollee

This rate is contingent upon the enrollment of a minimum of 75 percent of the eligible members of the defined group and their eligible dependents. In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for Cost of Claims for the preceding month on the first (1st) of each month. Payment shall be due on or before the twentieth (20th) of that month. Rates do not include any applicable claims taxes.

E. Performance Guarantee(s): See Addendum

DELTA DENTAL PLAN OF MICHIGAN, INC.

BY:

President and CEO

DATE: October 8, 2021

CONTRACTOR

BY:

(Authorized Signature)

(Title)

BY:

(Witnessed By)

(Title)

DATE:

ADDENDUM

St. Clair County
3636-2000, 2001, 2002
January 1, 2022

E. Performance Guarantee(s): The following Performance Guarantees have been agreed to by both parties.

In the event this Agreement is terminated by either party before its First Renewal Date, these Performance Guarantees are null and void. These Performance Guarantees will only be tracked, reported, and paid on a calendar-year basis for each full calendar year that this Agreement is in effect. In addition, if Delta Dental's performance meets or exceeds the guaranteed performance for three consecutive years, Delta Dental will have no further liability for tracking, reporting, or refunding administration costs for Performance Guarantees.

The total refund in any calendar year will not exceed 50 percent of Contractor's total annual administration costs. Total annual administration costs equal the annual exposure multiplied by the per Subscriber administration cost, excluding commissions, if payable.

1. Turnaround Time Guarantee

Delta Dental guarantees to process 95 percent of all dental claims for all Contractors within ten business days (measured from the date a completed claim is received to the date it is adjudicated in the claim system or denied).

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent below the 95 percent goal.

2. No Balance Billing Guarantee

When Dentists sign contracts to participate with Delta Dental, they agree to accept Delta Dental's determination of payment as the full fee for covered services. If a Participating Dentist's Submitted Fee is higher than the amount that Delta Dental approves, they agree not to charge the difference to Subscribers (or "balance bill" Subscribers). Delta Dental guarantees Subscribers will never have to pay that difference.

If a Subscriber is balance billed by a Participating Dentist, Delta Dental guarantees to investigate each occurrence and, when appropriate, to make the Subscriber whole.

3. Telephone Average Speed of Answer Guarantee

Delta Dental guarantees that the annual average speed of answer of all calls to Delta Dental's customer service department will be 25 seconds or less.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each second above 25 seconds.

4. Telephone Abandonment Rate Guarantee

Delta Dental guarantees that the annual call abandonment rate for Delta Dental's customer service department (or the rate of callers who hang up before their call is answered) will be five percent or less.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent that the call abandonment rate exceeds the five percent goal.

5. Claims Financial Accuracy Guarantee

Delta Dental guarantees that the financial accuracy rate, measured as the total claim dollars paid correctly divided by the total claim dollars audited in a statistically valid sample from all claims paid from all groups, with errors including the absolute value of all overpayments and underpayments, will be at least 99 percent.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 99 percent goal.

6. Claims Payment Accuracy Guarantee

Delta Dental guarantees that the payment accuracy rate, measured as the number of claims paid correctly divided by the number of claims audited in a statistically valid sample from all claims paid from all groups, with errors including all overpayments, underpayments, and dollars paid to the wrong payee, will be at least 98 percent.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 98 percent goal.

7. Claims Processing Accuracy Guarantee

Delta Dental guarantees that the processing accuracy rate, measured as the number of correctly processed paid claims divided by the total number of claims audited in a statistically valid sample from all claims paid from all groups, will be at least 98 percent. The processing accuracy rate measures all types of errors, not just financial errors.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 98 percent goal.

8. Satisfactory Account Management Guarantee

Delta Dental guarantees that the Contractor will be satisfied with the management of the account.

If the Contractor is not completely satisfied with its account management each calendar year as indicated by a grade of B or above on Delta Dental's annual account management report card, Delta Dental will refund five percent of the Contractor's total annual administration costs.

9. Member Satisfaction Guarantee

Delta Dental guarantees that at least 95 percent of respondents to Delta Dental's standard member satisfaction survey will be satisfied with us as a whole.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent that the overall member satisfaction rate is below the 95 percent goal.

10. Panel Savings Guarantee

Delta Dental guarantees that the Contractor's annual savings from fee and policy reductions, as reported on the Contractor's annual Treatment Savings report, will be at least 13 percent.

This percentage will be calculated by dividing (a) the sum of Fees not Allowed Due to Processing Policies, Fee Reduction (both Member and Non-member Dentists), and Savings from Dental Consultant Review by (b) total charges less Invalid Claims and All Other Savings.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund any deficit where the Contractor's actual annual percentage as defined above is not at least 13 percent, up to a maximum of 25 percent of the Contractor's total annual administration costs.

SECTION II - DEFINITIONS

The following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent. Capitalized words and terms not defined below are defined in the Certificate.

ADMINISTRATIVE SERVICE FEE means the fee charged by Delta Dental® for the administrative services performed under this Contract.

BENEFIT MANAGER TOOLKIT means Delta Dental's online portal used for eligibility updates and Dental Plan information.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CONTRACT means this document, including the Certificate and applicable Summary(ies) of Dental Plan Benefits (the terms of which are incorporated herein), the materials submitted by the Contractor in applying for coverage, and, if applicable, any appendices, supplements, riders, successor agreements, renewal letters, or renewals now or hereafter issued or executed.

COST OF CLAIMS means the total amount of Claims payments made by Delta Dental for Covered Services for which the Contractor must reimburse Delta Dental.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

SECTION III - ERISA

Contractor, or a person designated by Contractor (other than Delta Dental), shall be the Named Fiduciary of the Contractor's Dental Plan as that term is defined by ERISA §402(a)(2). To the extent Contractor has delegated to Delta Dental the responsibility and discretionary authority to make final claims determinations, Delta Dental shall be the named fiduciary with respect to such determinations. Any determination or interpretation made by Delta Dental pursuant to this authority is binding on the Member and the Contractor unless it is demonstrated that the determination was arbitrary and capricious. In the event final claims determinations are made by any other entity, Delta Dental shall not be a fiduciary with respect to such determinations. Furthermore, to the extent that Delta Dental is deemed to possess any plan assets of the Dental Plan, Delta Dental will be a fiduciary with respect to such assets to the extent that Delta Dental exercises discretion and control over such assets. Except as otherwise stated herein, Delta Dental shall not have any further discretionary authority or control respecting the management of the Dental Plan or the Dental Plan's assets, if any, and the Contractor retains all responsibility and authority, including all other fiduciary responsibilities, as defined in ERISA, for operation of the Dental Plan.

SECTION IV - ELIGIBILITY AND ENROLLMENT

- A. Contractor shall have sole responsibility for determining the eligibility of, and shall manage the enrollment, disenrollment, and contribution obligations of all Members.
- B. As a condition of enrollment, the Contractor shall require all Members to provide Delta Dental with all information needed to process claims and administer Benefits. Such information may include, but not be limited to, the Member's dental records. In the event a Member fails and/or refuses to provide Delta Dental with requested information, Delta Dental may place the Member's coverage on hold.
- C. Contractor shall provide Delta Dental with an initial eligibility upload of all Members. Such eligibility upload shall be in a form and format acceptable to Delta Dental. Thereafter, Contractor shall provide Delta Dental with eligibility updates on an as needed basis, which in no event shall be less than monthly. Contractor shall promptly respond to any requests for information made by Delta Dental concerning the eligibility of a Member.
- D. Contractor shall be solely responsible for the accuracy and delivery of all eligibility information submitted to Delta Dental. Delta Dental shall not be liable for any losses or damages resulting from eligibility information provided by Contractor and/or any other third party.
- E. Unless otherwise stated in the Declarations Section of this Contract, no retroactive eligibility updates will be accepted for an effective date more than six months from the date of notification. If the Contractor requests that a Enrollee's eligibility be terminated retroactively and a claim was incurred for that Enrollee or that Enrollee's Dependent after the requested termination date, the Enrollee's eligibility will continue until the end of the month in which the claim occurred, and Contractor shall be responsible for all Cost of Claims and applicable Administrative Service fees for services that were rendered to the Enrollee or Dependent up until the effective termination date. In addition, in the event that an Enrollee or Dependent is retroactively added, Contractor shall be responsible for all Cost of Claims and applicable Administrative Service fees for services that were rendered to the Enrollee or Dependent from the effective addition date forward.
- F. Upon reasonable prior written notice, Delta Dental shall have the right to audit the accuracy of Contractor's eligibility information. Contractor's refusal to permit such audit shall be deemed a material breach of this Contract.

- G. Contractor shall be solely responsible for identifying Members entitled to COBRA continuation benefits. Contractor shall provide all required notices, collect all necessary payments, and otherwise administer all facets of its COBRA program. In the event that Contractor continues to provide eligibility information to Delta Dental for a Member during the COBRA election period, as opposed to terminating coverage and then retroactively reinstating a Member upon the Member's election of COBRA coverage, Contractor shall be liable for any Claim paid during that period if the Member ultimately does not elect COBRA coverage.
- H. In the event that a Member undergoes a change in eligibility, Contractor must notify Delta Dental of such change. Any failure by Contractor to provide timely notice of eligibility changes may result in Benefits being improperly administered. Contractor shall be solely responsible for such failures. Contractor must notify Delta Dental immediately for any change in a Member's eligibility. In the event Contractor does not notify Delta Dental immediately, Contractor shall be responsible for any paid Claims.
- I. If the Contractor elects to transmit eligibility information via the Benefit Manager Toolkit, Contractor shall execute all proper authorization forms prior to accessing Delta Dental's systems.
- J. Delta Dental will deliver to the Contractor an electronic copy of the Certificate for distribution to each Enrollee, unless otherwise agreed to in writing by the Parties.
- K. The Contractor will timely distribute to each of its Enrollees the Certificates and other information provided by Delta Dental regarding the Benefits available under this Contract, unless otherwise agreed to in writing by the Parties.
- L. Delta Dental shall furnish the Contractor with enrollment forms and related informational materials necessary and appropriate to enroll the Contractor's Members. Delta Dental shall provide reasonable assistance to Contractor on an as needed basis during the enrollment process.
- M. In the event of any material changes in enrollment or composition of Members or if invoices are not paid as billed, unless otherwise agreed to in writing, Delta Dental shall have the right in its sole discretion to either:
1. Terminate this Contract pursuant to Section IX; or
 2. Propose an adjustment to the Administrative Service Fee. If the proposed adjustment to the Administrative Service Fee is not accepted by Contractor within 30 days of receipt of the proposed adjustment, Delta Dental reserves the right to terminate this Contract.

SECTION V - COVERED SERVICES

- A. Delta Dental shall administer and make payment for Covered Services in accordance with this Contract and the Certificate attached hereto. Contractor may request changes to the Covered Services available to Members by submitting the request in writing to Delta Dental. Changes to Covered Services are subject to Delta Dental's approval and may cause an increase to the Administrative Service Fee. Any changes to Covered Services must be agreed to in writing by Delta Dental prior to implementation. Contractor shall be responsible for determining all potential tax consequences relating to the covered benefits it selects.

SECTION VI - DELTA DENTAL NETWORK

- A. Delta Dental shall provide Members with an established network of dentists ("Participating Dentists") who have agreed to accept Delta Dental's Maximum Approved Fees for Covered Services. Delta Dental has complete discretion when setting the Maximum Approved Fees. For a detailed description of how payment is made, see Section VI of the applicable Certificate.
- B. Delta Dental shall ensure that there are an adequate number of qualified and credentialed Participating Dentists.
- C. Delta Dental is under no obligation to contract with any particular dentist and/or maintain any particular Participating Dentist in its network. In addition, Delta Dental is under no obligation to recommend or refer any dentist to a Member.
- D. Contractor acknowledges and agrees that:
1. Delta Dental does not provide, direct, or control the provision of dental services to Members.
 2. All decisions regarding dental services are made solely by the Member and his or her dentist; and
 3. Delta Dental does not warrant or guarantee that the dental services received by a Member from his or her dentist will be rendered in accordance with generally accepted standards or procedures.

SECTION VII - CLAIMS AND APPEALS

- A. Delta Dental will adjudicate and process all clean Claims submitted for Contractor's Dental Plan, in accordance with this Contract, the Certificate and Delta Dental's standard operating procedures. Clean Claims are those Claims that contain all information necessary for Delta Dental to process the Claim. In the event that Delta Dental does not receive a clean Claim, the Claim will be denied and will not be chargeable to the Member if the services were rendered by a Participating Dentist.

- B. Subject to the terms of this Contract and unless otherwise stated in the Declarations Section of this Contract, Delta Dental has complete discretion to process Claims received under Contractor's Dental Plan. As such, Delta Dental shall, without limitation, make determinations regarding:
1. Coordination of benefits;
 2. The applicability of Benefit waiting periods, limitations and exclusions; and
 3. The quality of care provided to Members by a treating dentist.
- C. Delta Dental shall provide Pre-Treatment Estimates to Members and Participating Dentists upon request as set forth in the Certificate. A Pre-Treatment Estimate is a voluntary and optional process where Delta Dental issues a written estimate of Benefits that may be available under the Dental Plan. A Pre-Treatment Estimate is not a prerequisite or condition for approval of future Benefits payment. Receipt of a Pre-Treatment Estimate does not guarantee payment or coverage, and is not a formal adjudication of a Claim. Pre-Treatment Estimates do not assess whether a Member is specifically eligible for a Covered Service or whether he or she has reached any applicable annual or lifetime maximum payments under the Dental Plan.
- D. Delta Dental will follow established procedures for resolving all adverse Claims determination questions asserted by a dentist or Member as set forth in the Certificate ("Claims Appeal Procedure"). The Claims Appeal Procedure shall contain processes for appealing initial adverse determinations made by Delta Dental. To the extent the Dental Plan is governed by ERISA, Delta Dental's procedures shall comply with ERISA and any regulations or guidelines thereunder. All determinations made according to the Claims Appeal Procedure will be final and binding on the Participating Dentist and the Member, unless otherwise stated in the Declarations Section of this Contract; provided, however, that the Member may exercise any additional legal rights he or she may have.
- E. Payments made directly to a Member as reimbursement for Covered Services under the Dental Plan are for the personal benefit of such Member and cannot be transferred or assigned unless otherwise stated in the Declarations Section of this Contract. Delta Dental shall not honor attempts to assign Benefits unless required by law.
- F. Delta Dental shall use reasonable efforts to recover any overpayments on Contractor's behalf. Delta Dental is under no obligation to engage in litigation in an attempt to recover such payments. Any funds recovered by Delta Dental will be properly credited to Contractor. Notwithstanding the foregoing, Delta Dental will be responsible for any overpayments made due to Delta Dental's negligence or breach of this Contract.
- G. Delta Dental does not insure or underwrite risk for Claims submitted on behalf of Members. The Contractor retains sole responsibility for all Claims properly paid by Delta Dental under this Contract.

SECTION VIII - PAYMENT

- A. The Contractor agrees to reimburse Delta Dental for the actual Cost of Claims and the invoiced Administrative Service Fee as set forth in the Declarations Section of this Contract. Delta Dental shall not be obligated to accept partial or late payments and acceptance of a partial or late payment will not waive Delta Dental's remedies under this Contract, or otherwise modify the terms herein.
- B. The Contractor shall maintain funds necessary to satisfy its obligations under this Contract.
- C. Unless otherwise stated in the Declarations Section of this Contract, payment for Administrative Service Fees shall be due on the fifth of each month. An invoice for the current month's Administrative Service Fees shall be sent on or about the third week of the preceding month.
- D. The Contractor is responsible for the full amount of all invoices regardless of any contribution owed by the Members to the Contractor. Delta Dental shall not be responsible for collecting any contributions from Members.
- E. If required by Delta Dental, Contractor shall deposit an amount specified in the Declarations Section of this Contract ("Prefund") with Delta Dental. The Prefund shall serve as a deposit to offset against any untimely or partial payments from Contractor. In the event Delta Dental uses any of the Prefund to offset untimely or partial payments, Delta Dental shall submit an invoice to the Contractor in the amount necessary to replenish the Prefund. If the Contractor fails to timely replenish the Prefund, Delta Dental shall be entitled to all remedies set forth in Section XI.

SECTION IX - TERM AND TERMINATION

- A. This Contract shall remain in full force and effect for the initial term commencing on the Effective Date and continuing until the First Renewal Date, as specified in the Declarations Section. Thereafter, the Contract may be renewed for subsequent terms as specified in the Declarations Section or in a renewal letter, unless Contractor or Delta Dental provides written notice of its intent not to renew at least thirty (30) days prior to the expiration of the then current term.

- B. In the event of a Party's material breach, the non-breaching Party may terminate this Contract by sending written notice to the breaching Party explaining in detail the nature of the breach and providing an opportunity to cure, which in no event shall be less than 30 days. In the event the material breach is not cured within the notice period, the non-breaching party may immediately terminate this Contract.
- C. Unless otherwise stated in the Declarations Section of this Contract, this Contract may be terminated by either Party without cause upon 60 days written notice to the other Party.
- D. There shall be a twelve month run-out period for all Claims incurred prior to the termination date, except in cases where Delta Dental has terminated this Contract for cause. All Claims paid by Delta Dental during this run-out period shall be invoiced to the Contractor in accordance with Section VIII of this Contract. Any Claims for services rendered after the termination date shall be denied. After the conclusion of the twelve month run out period, Claims shall be denied and Delta Dental shall not have any further obligations to the Contractor.
- E. Following the Claims run-out period, Delta Dental shall prepare a final settlement statement and invoice for Contractor. Such settlement statement and invoice shall detail the final amounts due and owing between the Parties including, to the extent applicable, any remaining Prefund deposited by the Contractor, all outstanding Administrative Service Fees and all remaining Claims payments made during the run-out period.
- F. Any false or misleading statements made by either Party shall be considered a material breach of this Contract.

SECTION X - CONFIDENTIALITY AND DISCLOSURE

- A. The Parties have entered into a Business Associate Agreement regarding the permissible use and disclosure of Member's protected health information as that term is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all subsequent amendments thereto. The Business Associate Agreement is attached as an Addendum hereto.
- B. The Parties acknowledge that in the course of performing under this Contract each Party may be provided with or given access to information, in oral, recorded or written form, that is proprietary and confidential to the other Party (collectively referred to as the "Confidential Information"). Such Confidential Information includes, but is not limited to: information regarding the other Party's management, business, organizational structure, policies, procedures, business relationships, intellectual property, copyrights, patents, trademarks, software, data, databases, system designs, specifications, documentation, code, architecture, structure, algorithms, techniques, processes, protocols, product materials, notes, slides, ideas, Maximum Approved Fees, Allowed Amounts, preferred provider reports, actuarial formulas, providers' personal information, and financial terms of this Contract.
- C. Confidential Information shall not include any information that:
 - 1. Is already known to the Party at the time of the disclosure (as evidenced by written documentation existing at that time);
 - 2. Is generally available to the public or becomes publicly known through no wrongful act of a Party; or
 - 3. Is received by a Party from a third-party who had a legal right to provide it (as evidenced by written documentation existing at that time).
- D. The Parties each will make all reasonable, necessary and appropriate efforts to safeguard each other's Confidential Information. Each Party will safeguard the other's Confidential Information to the same extent that it safeguards information relating to its own business, which in no event will be less than the safeguards that a reasonably prudent business would exercise under similar circumstances.
- E. Each Party agrees not to use, distribute or exploit each other's Confidential Information, in whole or in part, for its own benefit or that of any third party and will not disclose such Confidential Information to any other person or entity without each other's prior written consent. A Party shall be responsible for any breach of this Contract by its employees, authorized subcontractors, agents or representatives.
- F. Notwithstanding anything to the contrary in this Section, the Parties shall be permitted to disclose Confidential Information as required by order of a court of law, administrative agency, or other governmental body; provided, however, the Party shall provide reasonable advance written notice to the other Party to the extent allowed by law in order to allow that Party the opportunity to seek a protective order or otherwise limit such disclosure, and the disclosing Party shall reasonably cooperate with the other Party to limit any such disclosure or to seek a protective order. If a Party is nonetheless required to disclose the other Party's Confidential Information, said Party shall only disclose the minimum information necessary to respond to the legal request. Notwithstanding the foregoing, Delta Dental shall not be required to provide Contractor notice prior to responding to governmental agency subpoenas regarding potential provider fraud or abuse.

SECTION XI - RIGHTS AND REMEDIES

- A. In addition to the right of termination described in Section IX, Delta Dental shall have the following rights and remedies in the event Contractor fails to timely pay in full the Administrative Service Fees or reimburse Delta Dental for the Cost of Claims, subject to Contractor's right to cure pursuant to Section IX.B.:
 - 1. Delta Dental may retroactively terminate this Contract to the date it last received payment; and

2. Delta Dental may initiate proceedings to recover and collect all payments due and owing, as well as all costs associated with the collection proceedings including, but not limited to, attorneys' fees.
 3. Notwithstanding the foregoing, Delta Dental may immediately suspend payment of all Claims in the event that it does not receive timely payment of the Administrative Service Fees or reimbursement for the Cost of Claims.
- B. No claim, lawsuit or action, may be brought more than three years after the claim first arose.
- C. Either Party's failure to exercise any right or remedy contained herein shall not constitute a waiver of any future rights or remedies available to that Party.

SECTION XII - GENERAL PROVISIONS

- A. **Subrogation.** Delta Dental shall be subrogated to all of Contractor's rights with respect to any Claim(s). However, Delta Dental is not obligated to institute or become involved in any litigation concerning such Claim(s). If after six (6) months Delta Dental is unable recover through reasonable efforts, using its standard overpayment recovery processes, any amounts due and owing to Contractor, Delta Dental will provide Contractor with notice of any such unrecovered Claims. The decision to further pursue recovery of such Claims shall be within the sole discretion of Contractor and at Contractor's sole expense. Delta Dental will provide reasonable assistance to Contractor in any such recovery efforts, but in no event will Delta Dental be obligated to undertake any recovery litigation unless mutually agreed to by Delta Dental and Contractor. Delta Dental will remit to Contractor any applicable funds recovered from third parties, less any expenses it has incurred in its recovery efforts. Such funds shall be applied as a credit to Contractor's invoice(s). Contractor will assist Delta Dental as will be reasonably necessary for Delta Dental to carry out its duties under this provision. Delta Dental may assign or subcontract a portion of its duties under this provision of the Contract to others.
- B. **Right to Review Published Materials.** Contractor agrees not to publish or distribute any materials containing the logo, trademark, or business mark of Delta Dental, or containing a change in the benefits to be administered under this Contract, until Delta Dental reviews and, with respect to the use of Delta Dental's logo, trademark, or business mark, approves the materials. This provision does not apply to materials that Delta Dental has provided to Contractor for distribution.
- C. **Cooperation.** The Contractor shall provide Delta Dental with any information it may reasonably require to administer the Dental Plan or otherwise discharge its duties under this Contract.
- D. **Indemnification.**
1. Each Party agrees to defend, indemnify, and hold harmless the other Party and its directors, officers, affiliates, agents, and employees (who are acting in the course of their employment, but not as claimants) from any loss, cost, or expense (including reasonable attorney fees and court costs) ("Losses") resulting from or arising out of or in connection with the indemnifying Party's breach of this Contract, or any negligent act or omission of any of the indemnifying Party's directors, officers, agents or employees, unless liability for such act or omission is expressly assigned elsewhere in this Contract.
 2. The indemnifying Party shall provide prompt written notice of relevant information concerning any Losses to the indemnified Party. Reasonable assistance (at the indemnifying Party's expense) may be requested by the indemnified Party in connection with the defense of any Losses. Notwithstanding the foregoing:
 - a. The indemnified party shall permit the indemnifying Party to control the defense or settlement of the claim, suit or proceeding at the indemnifying party's expense;
 - b. The indemnified Party shall have the right to provide for its separate defense at its own expense;
 - c. Neither Party shall settle any Losses without the consent of the other Party, which consent shall not be unreasonably withheld. Any release obtained as a result of settlement must contain a release of all claims against the indemnified Party as well as its officers, directors and employees, and
 - d. The indemnification obligations of indemnifying Party hereunder shall not extend to Losses attributable to the negligence, intentional misconduct, or willful malfeasance of the indemnified Party.
- E. **Notice.** Any notice required or permitted to be given under this Contract will be considered given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the other Party at its last address of record.
- F. **Survival.** The following Sections shall survive expiration or early termination of this Contract: Section VIII. Payment; Section X. Confidentiality & Disclosure; Section XI. Rights and Remedies; and Section XII. General Provisions.
- G. **Internal Policies and Procedures.** Delta Dental has the right to amend its internal policies and procedures periodically and without notice to the Contractor to the extent the amendment does not affect the delivery of

benefits to Members. Delta Dental will provide advance written notice, to the extent possible, to Contractor of any amendment to Delta Dental's policies or procedures that affect the delivery of benefits to Members; if advance notice is not possible, Delta Dental will provide written notice as soon as possible after the amendment is adopted.

- H. **Third Party Beneficiaries.** This Contract will not confer any rights or remedies on any third-party, other than the Parties to this Contract and their respective successors and permitted assigns.
- I. **Assignment and Subcontracting.** Unless it has first obtained the written consent of the other Party, neither Party may assign this Contract or any of its rights or obligations under this Contract to any other person, except that Delta Dental may make assignments to its subsidiaries and affiliates without the prior written consent of the Contractor.
- J. **Integration.** This Contract constitutes the entire understanding between the Parties with respect to the subject matter of this Contract and supersedes any prior discussions, negotiations, agreements and understandings.
- K. **Force Majeure.** Unless otherwise stated in the Declarations Section of this Contract, neither Delta Dental (including its agents, directors, officers, and employees) nor Contractor shall be liable for delays in performance due to circumstances beyond their reasonable control. Each Party shall be excused from performance under this Contract and shall have no liability to the other Party for any period during which it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other Party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications, and such nonperformance shall not be a default under or grounds for termination of this Contract.
- L. **Applicable Law.** This Contract and the obligations of the Parties under this Contract will be governed by and construed in accordance with ERISA to the extent applicable. If it is determined by a court of competent jurisdiction that ERISA does not apply, the law of the State of Michigan will control.
- M. **Venue.** The Parties submit to the jurisdiction and venue of the Circuit Court of Ingham County, State of Michigan, or if original jurisdiction can be established in the United States District Court of Western Michigan.
- N. **Severability.** If any part of this Contract or an amendment of it is found by an arbitrator, court, or other authority to be illegal, void or not enforceable, all other portions of this Contract shall remain in full force and effect.
- O. **Counterparts.** This Contract may be executed in one or more counterparts, each of which will be deemed an original agreement, but all of which will be considered one instrument and will become a binding agreement when one or more counterparts have been signed by each of the Parties and delivered to the other. Electronic and/or fax signatures shall be accepted as original signatures.
- P. **Audits.** The Contractor shall have the right to audit Delta Dental's files, books, and records (both paper and electronic) pertaining to the administrative services provided under this Agreement. The Contractor will bear the entire cost of any such audits. The Contractor may assign this right to audit to an agent, provided the agent is a licensed firm and the audit is led by an individual who holds a nationally recognized audit accreditation. Delta Dental will allow the Contractor or the Contractor's agent to audit the work areas at which services under this Contract are performed, within 14 business days of receipt of a fully-signed confidentiality agreement. Where applicable, Delta Dental agrees to segregate the Contractor's records from third-party records in order to allow accurate assessment of Contractor-specific processes. Such audits will take place no more than once in a 12-month period, unless both the Contractor and Delta Dental mutually agree that there is reasonable cause to conduct an audit more frequently, in which case the Contractor will give 14 business days' written notice before such audit. The scope of any audit conducted under this provision must be mutually agreed upon, in writing, by both parties prior to the start of the audit. Notwithstanding the foregoing, Contractor shall not have the right to audit any information which Delta Dental, in its sole discretion, determines is proprietary. During the audit, if claims samples are selected using a financially stratified methodology, the results shall be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.
- Q. **Other Goods and Services.** From time to time, Delta Dental may offer or provide Members certain goods and services, including discounts on dental services provided by Participating Dentists in addition to the dental coverage (including without limitation toothbrushes, dental floss and other oral hygienic devices/products). Delta Dental also may arrange for third party vendors to provide goods and services at a discount to Members. Though Delta Dental may make the arrangements, the third party vendors are solely liable for providing the goods and services. Delta Dental shall not be responsible for providing or failing to provide the goods and services to Members. Further, Delta Dental shall not be liable to Members for negligent provision of the goods and services by third party vendors. Delta Dental reserves the right to terminate or change these goods or services at any time.



Delta Dental PPO™ (Point-of-Service) Summary of Dental Plan Benefits For Group# 3636-2000, 2001, 2002 St. Clair County

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	50%	50%	50%
Emergency Palliative Treatment – to temporarily relieve pain	50%	50%	50%
Sealants – to prevent decay of permanent teeth	50%	50%	50%
Brush Biopsy – to detect oral cancer	50%	50%	50%
Radiographs – X-rays	50%	50%	50%
Basic Services			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to prosthetic appliances	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable with no limitations.
- Space maintainers are payable once per area per lifetime for people age 15 and under.
- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per five-year period for first and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.

- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services.

Deductible – None.

Waiting Period – Enrollees who are eligible for dental benefits are covered on the date of enrollment.

Eligible People – Any retiree of the county eligible for benefits in accordance with the 'Retiree Ordinances': SCC Retirees (2000), SCC Road Commission Retirees (2001), SCC-CMH Retirees (2002) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable.

Also eligible at your option are your legal spouse and your dependent unmarried children under age 22 if eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year. Also eligible is your domestic partner, as defined by the Contractor.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the date of termination.

Delta Dental PPOTM

Our national PPO program

Welcome!

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan. Delta Dental of Michigan is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 800-524-0149 or access our website at www.DeltaDentalMI.com.

You can easily verify your own Benefit, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalMI.com and selecting the link for our Consumer Toolkit®. The Consumer Toolkit will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

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Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

I. Delta Dental PPO Certificate

Delta Dental Plan of Michigan, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Enrollee. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and the Contractor.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Goran M. Jurkovic, CPA, CGMA
President and CEO
Delta Dental Plan of Michigan, Inc.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

The amount permitted under the applicable fee schedule for This Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year

The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year, unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and the Contractor.

Child(ren)

Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim

A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- ◆ For dentures and partial dentures, on the delivery dates;
- ◆ For crowns and bridgework, on the permanent cementation date;
- ◆ For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment

The percentage of the charge, if any, that you must pay for Covered Services.

Contractor

The employer, organization, group, or association sponsoring This Plan.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Member Plan

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

Delta Dental Premier® Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Member Plan.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- ◆ **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
- ◆ **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
- ◆ **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.
- ◆ **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Delta Dental Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Delta Dental Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists."**

Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dependent(s)

Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits

Enrollee

You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Maximum Approved Fee

The Maximum Approved Fee is the lowest of:

- ◆ The Submitted Amount
- ◆ The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- ◆ The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Member(s)

Any Enrollee or Dependent with coverage under This Plan.

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period

The period of time, as determined by the Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate

A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Special Enrollment Period

A period outside of the Open Enrollment Period in which you or your Dependent can obtain coverage under This Plan due to a qualifying life event.

Spouse

Your legal spouse.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Members pursuant to this Certificate and your Summary of Dental Plan Benefits.

III. Enrolling in This Plan

The Open Enrollment Period, if applicable, will be established by the Contractor and will occur on an annual basis. During the Open Enrollment Period, all eligible persons as defined in your Summary of Dental Plan Benefits may enroll in This Plan. You and/or your Dependents may not enroll in This Plan at any other time during the applicable Benefit Year except in the following instances:

- a. Newly hired or rehired employees (if applicable): You will be eligible to enroll on the date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Dental Plan Benefits.
- b. New Spouse: Your new Spouse will be eligible to enroll on the date of marriage.
- c. Newborn: Your newborn will be eligible to enroll on the date of birth.
- d. Legal adoptions or guardianships: Your newly adopted Child(ren) and/or the minor Child(ren) that you and/or your Spouse have guardianship over will be eligible to enroll on the date that the legal petition for adoption or guardianship becomes legally final, or the date on which the Child(ren) begins residing with the Enrollee and the Enrollee assumes responsibility for the Child(ren) while waiting for adoption or guardianship to become final.
- e. New Stepchild: Your new stepchild will be eligible to enroll on the date that the Child's natural parent becomes a Dependent.
- f. To the extent Contractor permits Dependents other than those defined in this Certificate to enroll in This Plan, such Dependents will be eligible to enroll on the date that they become an eligible Dependent. Any such additional Dependents permitted by Contractor shall be set forth in your Summary of Dental Plan Benefits.
- g. All others will be permitted on the date that Delta Dental approves in

writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Dependent.

IV. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.DeltaDentalMI.com or call 800-524-0149.

V. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at 800-524-0149.
3. After you receive your dental treatment, you or the dental office staff will file a Claim form, completing the information portion with:
 - a. The Enrollee's full name and address
 - b. The Enrollee's Member ID number
 - c. The name and date of birth of the person receiving dental care
 - d. The Contractor's name and number

Notice of Claim Forms

Delta Dental does not require special Claim forms. However, most dental offices have Claim forms available. Participating Dentists will fill out and submit your dental Claims for you.

Mail Claims and completed information requests to:

**Delta Dental
P.O. Box 9085
Farmington Hills, Michigan 48333-9085**

Pre-Treatment Estimate

A Pre-Treatment Estimate is not required to receive payment, but it allows Claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a Claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under This Plan are post-service Claims. All Claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a Claim is filed, Delta Dental will adjudicate it within 30 days of receiving it. If there is not enough information to adjudicate your Claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the Claim, and (d) inform you or your Dentist that the information must be received within 45 days or your Claim will be Denied if the services were performed by a Nonparticipating Dentist, or not chargeable to the Member if the services were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to adjudicate your Claim. If you or your Dentist does not supply the requested information, Delta Dental will deny your Claim. In such case, you will be responsible for all charges if the services were performed by a Nonparticipating Dentist. If the services were performed by a Participating Dentist, the services will not be chargeable to the Member. Once Delta Dental adjudicates your Claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Contractor, call Delta Dental's Customer Service department, toll-free, at 800-524-0149, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to designate the person you wish to appoint as your representative. Delta Dental will only recognize the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to your Contractor or call Delta Dental's Customer Service department, toll-free, at 800-

524-0149. You may also write to Delta Dental's Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing to Delta Dental, please include your name, the Contractor's name and number, the Enrollee's Member ID number, and your daytime telephone number.

VI. How Payment is Made

Delta Dental shall make payments for Covered Services in accordance with the type of plan selected by the Contractor. The type of plan selected will be identified on your Summary of Dental Plan Benefits.

Delta Dental PPO (Point-of-Service)

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the Nonparticipating Dentist Fee for Covered Services.

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Delta Dental PPO (Standard)

Regardless of your Dentist's participating status, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. If your Dentist is not a PPO Dentist, but is a Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Orthodontics

If This Plan includes orthodontics it will be identified on and paid as reflected in your Summary of Dental Plan Benefits.

Covered Services Requiring Multiple Visits

In the event a Covered Service requires more than one (1) visit with your Dentist, payment for the Covered Service will be rendered upon Completion Date.

VII. Benefit Categories

The Benefits covered by This Plan are set forth in your Summary of Dental Plan Benefits.

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.

7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered under the terms of this Certificate.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract between Delta Dental and the Contractor.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision abutments, attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
42. Myofunctional therapy.
43. Mounted case analyses.
44. Antigen or antibody testing for a public health related pathogen.
45. Any and all taxes applicable to the services.

46. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Caries risk assessment performed on a Member age 2 or under.
5. Local anesthesia.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy as an aid to the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
27. Full mouth debridement, when done on the same day as comprehensive evaluation.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.

31. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
32. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
33. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
34. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
35. Capture only images which are not associated with any interpretation or reporting.
36. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
37. Implant removal when performed within three (3) months of an implant/mini-implant on the same tooth by the same dentist or dental office.
38. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.
6. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age 8 and under.
10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restoration on the same tooth are also subject to this five-year limitation.
11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
14. Hard full or partial arch occlusal guards are payable once in a lifetime.
15. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over.
16. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36 month period.
17. Prosthodontic Services limitations:
 - a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
 - b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - c. A removable unilateral partial denture is payable once per quadrant in any 5 year period unless the loss of additional teeth requires the construction of a new appliance.

- d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.
 - e. A relined or the complete replacement of denture base material is payable once in any three-year period per appliance.
 - f. Implant removal is payable once per lifetime per tooth or area.
 - g. Implant maintenance is payable once per any twelve (12) month period.
 - h. Removal of a broken implant retaining screw is payable once in a 5 year period.
18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:
- a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.
 - b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
 - c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.
20. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily

provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

- a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
 - b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
 - d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
 - e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
 - f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
 - h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
23. Maximum Payment:
- a. All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

25. Caries risk assessments are payable once in any 12-month period for Members age 3-18.
26. Assessments of salivary flow by measurement are payable once in any 36-month period.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
29. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five (5) applications per day.
30. Sealants are covered once per tooth per lifetime on first permanent molars for Members age 9 and under.
31. Sealants are covered once per lifetime on second permanent molars for members age 14 and under.
32. One cone beam CT is allowed within a twelve (12) month period except when performed for TMD treatment.
33. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a twelve (12) month period when done by the same dentist/dental office.
16. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same dentist/dental office.
17. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

IX. Coordination of Benefits

Coordination of Benefits (“COB”) applies to This Plan when a Member has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan’s Benefits are determined before or after another plan’s benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your Claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the Member to This Plan’s Enrollee, as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another plan that does not coordinate benefits, it will always be primary.

2. Enrollee v. Dependent Coverage

The plan that covers the Member as an Enrollee will be primary over a plan that covers the Member as a dependent. However, please note that if the Member is a Medicare beneficiary, federal law may reverse this order.

3. Children (Parents Divorced or Separated)

If a court decree makes one parent responsible for health care expenses, that parent’s plan is primary.

If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the Child’s health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

If neither of these rules applies, the order will be determined as follows:

- a. First, the plan of the parent with custody of the Child will be primary;
- b. Then, the plan of the spouse of the parent with custody of the Child will be primary;
- c. Next, the plan of the parent without custody of the Child will be primary; and
- d. Last, the plan of the spouse of the parent without custody of the Child will be primary.

4. Children and the Birthday Rule

The plan of the parent whose birthday is earliest in the calendar year is always primary for Children. For example, if your birthday is in

January and your spouse’s birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Laid Off or Retired Employees

The plan that covers the Member as a laid off or retired employee or as a dependent of a laid off or retired employee will be primary.

6. COBRA Coverage

The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA) will be primary.

7. Other Plans

If none of the rules above determines the order of benefits, the plan that has covered the Member for the longer period will be primary.

If the other plan does not have rule 5 and/or rule 6 (above) and decides the order of benefits differently from This Plan, This Plan may ignore either of those rules.

In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures for determining which plan is primary, unless prohibited by applicable law.

How Delta Dental Pays as Primary Plan

When Delta Dental is the primary plan, it will pay for Covered Services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan.

When Benefits are reduced as described above, each Benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person regarding the Claim being coordinated. Delta Dental need not tell or get the consent of any person to do this. Each person claiming Benefits

under This Plan must give Delta Dental any facts it needs to pay the Claim.

Facility of Payment

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

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

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, Delta Dental may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Member.

Payment includes the reasonable cash value of any benefits provided in the form of services.

X. Reconsideration and Claims Appeal Procedure

Reconsideration

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental’s Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you

can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

**Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916**

Please include your name and address, the Enrollee’s Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer’s decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person’s subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

XI. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- ◆ When the Contractor advises Delta Dental to terminate your coverage.
- ◆ On the first day of the month for which the Contractor has failed to pay Delta Dental.
- ◆ For fraud or misrepresentation in the submission of any Claim.
- ◆ For your Dependent, when they no longer qualify as a Dependent.
- ◆ For any other reason stated in the Contract between Delta Dental and the Contractor.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XII. Continuation of Coverage

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

1. Your employment, if applicable, ends for any reason other than your gross misconduct.
2. You do not qualify as an Enrollee as set forth in your Summary of Dental Plan Benefits.
3. You are divorced or legally separated.
4. You die.
5. Your Dependent is no longer a Dependent.
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XIII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide

payments or benefits for the Covered Services that were paid for by Delta Dental,

2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a Claim for such has not been received by

Delta Dental within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will deny that portion of the Claim that Delta Dental would have paid if the Claim had been timely submitted, and such denied portion of the Claim will not be chargeable to the Member. However, you will remain responsible for any applicable Deductible and/or Copayment. In the event that a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group Contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any

payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800-524-0147



Delta Dental Service Contract For St. Clair County

This Service Contract ("Contract") is entered into by and between St. Clair County (the "Contractor") and Delta Dental Plan of Michigan, Inc., a Michigan non-profit corporation ("Delta Dental"). Delta Dental agrees to perform claims administration services for the Contractor's self-funded dental benefit plan. Contractor and Delta Dental may be singularly referred to herein as "Party" and collectively referred to herein as the "Parties". This is a legally binding contract between the Contractor and Delta Dental and is effective on January 1, 2022, the ("Effective Date").

SECTION I - DECLARATIONS

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

A. Effective Date: 12:01 A.M. Standard Time, January 1, 2022

B. First Renewal Date: January 1, 2025

C. Client Number: 3636-3000, 3099

D. Rate(s):

Administrative Service Fee: Composite - \$4.07 per month per Enrollee

This rate is contingent upon the enrollment of a minimum of 75 percent of the eligible members of the defined group and their eligible dependents. In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for Cost of Claims for the preceding month on the first (1st) of each month. Payment shall be due on or before the twentieth (20th) of that month. Rates do not include any applicable claims taxes.

E. Performance Guarantee(s): See Addendum

DELTA DENTAL PLAN OF MICHIGAN, INC.

BY:

President and CEO

DATE: October 8, 2021

CONTRACTOR

BY:

(Authorized Signature)

(Title)

BY:

(Witnessed By)

(Title)

DATE:

ADDENDUM

St. Clair County
3636-3000, 3099
January 1, 2022

E. Performance Guarantee(s): The following Performance Guarantees have been agreed to by both parties.

In the event this Agreement is terminated by either party before its First Renewal Date, these Performance Guarantees are null and void. These Performance Guarantees will only be tracked, reported, and paid on a calendar-year basis for each full calendar year that this Agreement is in effect. In addition, if Delta Dental's performance meets or exceeds the guaranteed performance for three consecutive years, Delta Dental will have no further liability for tracking, reporting, or refunding administration costs for Performance Guarantees.

The total refund in any calendar year will not exceed 50 percent of Contractor's total annual administration costs. Total annual administration costs equal the annual exposure multiplied by the per Subscriber administration cost, excluding commissions, if payable.

1. Turnaround Time Guarantee

Delta Dental guarantees to process 95 percent of all dental claims for all Contractors within ten business days (measured from the date a completed claim is received to the date it is adjudicated in the claim system or denied).

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent below the 95 percent goal.

2. No Balance Billing Guarantee

When Dentists sign contracts to participate with Delta Dental, they agree to accept Delta Dental's determination of payment as the full fee for covered services. If a Participating Dentist's Submitted Fee is higher than the amount that Delta Dental approves, they agree not to charge the difference to Subscribers (or "balance bill" Subscribers). Delta Dental guarantees Subscribers will never have to pay that difference.

If a Subscriber is balance billed by a Participating Dentist, Delta Dental guarantees to investigate each occurrence and, when appropriate, to make the Subscriber whole.

3. Telephone Average Speed of Answer Guarantee

Delta Dental guarantees that the annual average speed of answer of all calls to Delta Dental's customer service department will be 25 seconds or less.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each second above 25 seconds.

4. Telephone Abandonment Rate Guarantee

Delta Dental guarantees that the annual call abandonment rate for Delta Dental's customer service department (or the rate of callers who hang up before their call is answered) will be five percent or less.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent that the call abandonment rate exceeds the five percent goal.

5. Claims Financial Accuracy Guarantee

Delta Dental guarantees that the financial accuracy rate, measured as the total claim dollars paid correctly divided by the total claim dollars audited in a statistically valid sample from all claims paid from all groups, with errors including the absolute value of all overpayments and underpayments, will be at least 99 percent.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 99 percent goal.

6. Claims Payment Accuracy Guarantee

Delta Dental guarantees that the payment accuracy rate, measured as the number of claims paid correctly divided by the number of claims audited in a statistically valid sample from all claims paid from all groups, with errors including all overpayments, underpayments, and dollars paid to the wrong payee, will be at least 98 percent.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 98 percent goal.

7. Claims Processing Accuracy Guarantee

Delta Dental guarantees that the processing accuracy rate, measured as the number of correctly processed paid claims divided by the total number of claims audited in a statistically valid sample from all claims paid from all groups, will be at least 98 percent. The processing accuracy rate measures all types of errors, not just financial errors.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent of claims paid below the 98 percent goal.

8. Satisfactory Account Management Guarantee

Delta Dental guarantees that the Contractor will be satisfied with the management of the account.

If the Contractor is not completely satisfied with its account management each calendar year as indicated by a grade of B or above on Delta Dental's annual account management report card, Delta Dental will refund five percent of the Contractor's total annual administration costs.

9. Member Satisfaction Guarantee

Delta Dental guarantees that at least 95 percent of respondents to Delta Dental's standard member satisfaction survey will be satisfied with us as a whole.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund one percent of the Contractor's total annual administration costs for each one percent that the overall member satisfaction rate is below the 95 percent goal.

10. Panel Savings Guarantee

Delta Dental guarantees that the Contractor's annual savings from fee and policy reductions, as reported on the Contractor's annual Treatment Savings report, will be at least 13 percent.

This percentage will be calculated by dividing (a) the sum of Fees not Allowed Due to Processing Policies, Fee Reduction (both Member and Non-member Dentists), and Savings from Dental Consultant Review by (b) total charges less Invalid Claims and All Other Savings.

If Delta Dental does not meet this guarantee each calendar year, Delta Dental will refund any deficit where the Contractor's actual annual percentage as defined above is not at least 13 percent, up to a maximum of 25 percent of the Contractor's total annual administration costs.

SECTION II - DEFINITIONS

The following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent. Capitalized words and terms not defined below are defined in the Certificate.

ADMINISTRATIVE SERVICE FEE means the fee charged by Delta Dental® for the administrative services performed under this Contract.

BENEFIT MANAGER TOOLKIT means Delta Dental's online portal used for eligibility updates and Dental Plan information.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CONTRACT means this document, including the Certificate and applicable Summary(ies) of Dental Plan Benefits (the terms of which are incorporated herein), the materials submitted by the Contractor in applying for coverage, and, if applicable, any appendices, supplements, riders, successor agreements, renewal letters, or renewals now or hereafter issued or executed.

COST OF CLAIMS means the total amount of Claims payments made by Delta Dental for Covered Services for which the Contractor must reimburse Delta Dental.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

SECTION III - ERISA

Contractor, or a person designated by Contractor (other than Delta Dental), shall be the Named Fiduciary of the Contractor's Dental Plan as that term is defined by ERISA §402(a)(2). To the extent Contractor has delegated to Delta Dental the responsibility and discretionary authority to make final claims determinations, Delta Dental shall be the named fiduciary with respect to such determinations. Any determination or interpretation made by Delta Dental pursuant to this authority is binding on the Member and the Contractor unless it is demonstrated that the determination was arbitrary and capricious. In the event final claims determinations are made by any other entity, Delta Dental shall not be a fiduciary with respect to such determinations. Furthermore, to the extent that Delta Dental is deemed to possess any plan assets of the Dental Plan, Delta Dental will be a fiduciary with respect to such assets to the extent that Delta Dental exercises discretion and control over such assets. Except as otherwise stated herein, Delta Dental shall not have any further discretionary authority or control respecting the management of the Dental Plan or the Dental Plan's assets, if any, and the Contractor retains all responsibility and authority, including all other fiduciary responsibilities, as defined in ERISA, for operation of the Dental Plan.

SECTION IV - ELIGIBILITY AND ENROLLMENT

- A. Contractor shall have sole responsibility for determining the eligibility of, and shall manage the enrollment, disenrollment, and contribution obligations of all Members.
- B. As a condition of enrollment, the Contractor shall require all Members to provide Delta Dental with all information needed to process claims and administer Benefits. Such information may include, but not be limited to, the Member's dental records. In the event a Member fails and/or refuses to provide Delta Dental with requested information, Delta Dental may place the Member's coverage on hold.
- C. Contractor shall provide Delta Dental with an initial eligibility upload of all Members. Such eligibility upload shall be in a form and format acceptable to Delta Dental. Thereafter, Contractor shall provide Delta Dental with eligibility updates on an as needed basis, which in no event shall be less than monthly. Contractor shall promptly respond to any requests for information made by Delta Dental concerning the eligibility of a Member.
- D. Contractor shall be solely responsible for the accuracy and delivery of all eligibility information submitted to Delta Dental. Delta Dental shall not be liable for any losses or damages resulting from eligibility information provided by Contractor and/or any other third party.
- E. Unless otherwise stated in the Declarations Section of this Contract, no retroactive eligibility updates will be accepted for an effective date more than six months from the date of notification. If the Contractor requests that a Enrollee's eligibility be terminated retroactively and a claim was incurred for that Enrollee or that Enrollee's Dependent after the requested termination date, the Enrollee's eligibility will continue until the end of the month in which the claim occurred, and Contractor shall be responsible for all Cost of Claims and applicable Administrative Service fees for services that were rendered to the Enrollee or Dependent up until the effective termination date. In addition, in the event that an Enrollee or Dependent is retroactively added, Contractor shall be responsible for all Cost of Claims and applicable Administrative Service fees for services that were rendered to the Enrollee or Dependent from the effective addition date forward.
- F. Upon reasonable prior written notice, Delta Dental shall have the right to audit the accuracy of Contractor's eligibility information. Contractor's refusal to permit such audit shall be deemed a material breach of this Contract.

- G. Contractor shall be solely responsible for identifying Members entitled to COBRA continuation benefits. Contractor shall provide all required notices, collect all necessary payments, and otherwise administer all facets of its COBRA program. In the event that Contractor continues to provide eligibility information to Delta Dental for a Member during the COBRA election period, as opposed to terminating coverage and then retroactively reinstating a Member upon the Member's election of COBRA coverage, Contractor shall be liable for any Claim paid during that period if the Member ultimately does not elect COBRA coverage.
- H. In the event that a Member undergoes a change in eligibility, Contractor must notify Delta Dental of such change. Any failure by Contractor to provide timely notice of eligibility changes may result in Benefits being improperly administered. Contractor shall be solely responsible for such failures. Contractor must notify Delta Dental immediately for any change in a Member's eligibility. In the event Contractor does not notify Delta Dental immediately, Contractor shall be responsible for any paid Claims.
- I. If the Contractor elects to transmit eligibility information via the Benefit Manager Toolkit, Contractor shall execute all proper authorization forms prior to accessing Delta Dental's systems.
- J. Delta Dental will deliver to the Contractor an electronic copy of the Certificate for distribution to each Enrollee, unless otherwise agreed to in writing by the Parties.
- K. The Contractor will timely distribute to each of its Enrollees the Certificates and other information provided by Delta Dental regarding the Benefits available under this Contract, unless otherwise agreed to in writing by the Parties.
- L. Delta Dental shall furnish the Contractor with enrollment forms and related informational materials necessary and appropriate to enroll the Contractor's Members. Delta Dental shall provide reasonable assistance to Contractor on an as needed basis during the enrollment process.
- M. In the event of any material changes in enrollment or composition of Members or if invoices are not paid as billed, unless otherwise agreed to in writing, Delta Dental shall have the right in its sole discretion to either:
1. Terminate this Contract pursuant to Section IX; or
 2. Propose an adjustment to the Administrative Service Fee. If the proposed adjustment to the Administrative Service Fee is not accepted by Contractor within 30 days of receipt of the proposed adjustment, Delta Dental reserves the right to terminate this Contract.

SECTION V - COVERED SERVICES

- A. Delta Dental shall administer and make payment for Covered Services in accordance with this Contract and the Certificate attached hereto. Contractor may request changes to the Covered Services available to Members by submitting the request in writing to Delta Dental. Changes to Covered Services are subject to Delta Dental's approval and may cause an increase to the Administrative Service Fee. Any changes to Covered Services must be agreed to in writing by Delta Dental prior to implementation. Contractor shall be responsible for determining all potential tax consequences relating to the covered benefits it selects.

SECTION VI - DELTA DENTAL NETWORK

- A. Delta Dental shall provide Members with an established network of dentists ("Participating Dentists") who have agreed to accept Delta Dental's Maximum Approved Fees for Covered Services. Delta Dental has complete discretion when setting the Maximum Approved Fees. For a detailed description of how payment is made, see Section VI of the applicable Certificate.
- B. Delta Dental shall ensure that there are an adequate number of qualified and credentialed Participating Dentists.
- C. Delta Dental is under no obligation to contract with any particular dentist and/or maintain any particular Participating Dentist in its network. In addition, Delta Dental is under no obligation to recommend or refer any dentist to a Member.
- D. Contractor acknowledges and agrees that:
1. Delta Dental does not provide, direct, or control the provision of dental services to Members.
 2. All decisions regarding dental services are made solely by the Member and his or her dentist; and
 3. Delta Dental does not warrant or guarantee that the dental services received by a Member from his or her dentist will be rendered in accordance with generally accepted standards or procedures.

SECTION VII - CLAIMS AND APPEALS

- A. Delta Dental will adjudicate and process all clean Claims submitted for Contractor's Dental Plan, in accordance with this Contract, the Certificate and Delta Dental's standard operating procedures. Clean Claims are those Claims that contain all information necessary for Delta Dental to process the Claim. In the event that Delta Dental does not receive a clean Claim, the Claim will be denied and will not be chargeable to the Member if the services were rendered by a Participating Dentist.

- B. Subject to the terms of this Contract and unless otherwise stated in the Declarations Section of this Contract, Delta Dental has complete discretion to process Claims received under Contractor's Dental Plan. As such, Delta Dental shall, without limitation, make determinations regarding:
1. Coordination of benefits;
 2. The applicability of Benefit waiting periods, limitations and exclusions; and
 3. The quality of care provided to Members by a treating dentist.
- C. Delta Dental shall provide Pre-Treatment Estimates to Members and Participating Dentists upon request as set forth in the Certificate. A Pre-Treatment Estimate is a voluntary and optional process where Delta Dental issues a written estimate of Benefits that may be available under the Dental Plan. A Pre-Treatment Estimate is not a prerequisite or condition for approval of future Benefits payment. Receipt of a Pre-Treatment Estimate does not guarantee payment or coverage, and is not a formal adjudication of a Claim. Pre-Treatment Estimates do not assess whether a Member is specifically eligible for a Covered Service or whether he or she has reached any applicable annual or lifetime maximum payments under the Dental Plan.
- D. Delta Dental will follow established procedures for resolving all adverse Claims determination questions asserted by a dentist or Member as set forth in the Certificate ("Claims Appeal Procedure"). The Claims Appeal Procedure shall contain processes for appealing initial adverse determinations made by Delta Dental. To the extent the Dental Plan is governed by ERISA, Delta Dental's procedures shall comply with ERISA and any regulations or guidelines thereunder. All determinations made according to the Claims Appeal Procedure will be final and binding on the Participating Dentist and the Member, unless otherwise stated in the Declarations Section of this Contract; provided, however, that the Member may exercise any additional legal rights he or she may have.
- E. Payments made directly to a Member as reimbursement for Covered Services under the Dental Plan are for the personal benefit of such Member and cannot be transferred or assigned unless otherwise stated in the Declarations Section of this Contract. Delta Dental shall not honor attempts to assign Benefits unless required by law.
- F. Delta Dental shall use reasonable efforts to recover any overpayments on Contractor's behalf. Delta Dental is under no obligation to engage in litigation in an attempt to recover such payments. Any funds recovered by Delta Dental will be properly credited to Contractor. Notwithstanding the foregoing, Delta Dental will be responsible for any overpayments made due to Delta Dental's negligence or breach of this Contract.
- G. Delta Dental does not insure or underwrite risk for Claims submitted on behalf of Members. The Contractor retains sole responsibility for all Claims properly paid by Delta Dental under this Contract.

SECTION VIII - PAYMENT

- A. The Contractor agrees to reimburse Delta Dental for the actual Cost of Claims and the invoiced Administrative Service Fee as set forth in the Declarations Section of this Contract. Delta Dental shall not be obligated to accept partial or late payments and acceptance of a partial or late payment will not waive Delta Dental's remedies under this Contract, or otherwise modify the terms herein.
- B. The Contractor shall maintain funds necessary to satisfy its obligations under this Contract.
- C. Unless otherwise stated in the Declarations Section of this Contract, payment for Administrative Service Fees shall be due on the fifth of each month. An invoice for the current month's Administrative Service Fees shall be sent on or about the third week of the preceding month.
- D. The Contractor is responsible for the full amount of all invoices regardless of any contribution owed by the Members to the Contractor. Delta Dental shall not be responsible for collecting any contributions from Members.
- E. If required by Delta Dental, Contractor shall deposit an amount specified in the Declarations Section of this Contract ("Prefund") with Delta Dental. The Prefund shall serve as a deposit to offset against any untimely or partial payments from Contractor. In the event Delta Dental uses any of the Prefund to offset untimely or partial payments, Delta Dental shall submit an invoice to the Contractor in the amount necessary to replenish the Prefund. If the Contractor fails to timely replenish the Prefund, Delta Dental shall be entitled to all remedies set forth in Section XI.

SECTION IX - TERM AND TERMINATION

- A. This Contract shall remain in full force and effect for the initial term commencing on the Effective Date and continuing until the First Renewal Date, as specified in the Declarations Section. Thereafter, the Contract may be renewed for subsequent terms as specified in the Declarations Section or in a renewal letter, unless Contractor or Delta Dental provides written notice of its intent not to renew at least thirty (30) days prior to the expiration of the then current term.

- B. In the event of a Party's material breach, the non-breaching Party may terminate this Contract by sending written notice to the breaching Party explaining in detail the nature of the breach and providing an opportunity to cure, which in no event shall be less than 30 days. In the event the material breach is not cured within the notice period, the non-breaching party may immediately terminate this Contract.
- C. Unless otherwise stated in the Declarations Section of this Contract, this Contract may be terminated by either Party without cause upon 60 days written notice to the other Party.
- D. There shall be a twelve month run-out period for all Claims incurred prior to the termination date, except in cases where Delta Dental has terminated this Contract for cause. All Claims paid by Delta Dental during this run-out period shall be invoiced to the Contractor in accordance with Section VIII of this Contract. Any Claims for services rendered after the termination date shall be denied. After the conclusion of the twelve month run out period, Claims shall be denied and Delta Dental shall not have any further obligations to the Contractor.
- E. Following the Claims run-out period, Delta Dental shall prepare a final settlement statement and invoice for Contractor. Such settlement statement and invoice shall detail the final amounts due and owing between the Parties including, to the extent applicable, any remaining Prefund deposited by the Contractor, all outstanding Administrative Service Fees and all remaining Claims payments made during the run-out period.
- F. Any false or misleading statements made by either Party shall be considered a material breach of this Contract.

SECTION X - CONFIDENTIALITY AND DISCLOSURE

- A. The Parties have entered into a Business Associate Agreement regarding the permissible use and disclosure of Member's protected health information as that term is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all subsequent amendments thereto. The Business Associate Agreement is attached as an Addendum hereto.
- B. The Parties acknowledge that in the course of performing under this Contract each Party may be provided with or given access to information, in oral, recorded or written form, that is proprietary and confidential to the other Party (collectively referred to as the "Confidential Information"). Such Confidential Information includes, but is not limited to: information regarding the other Party's management, business, organizational structure, policies, procedures, business relationships, intellectual property, copyrights, patents, trademarks, software, data, databases, system designs, specifications, documentation, code, architecture, structure, algorithms, techniques, processes, protocols, product materials, notes, slides, ideas, Maximum Approved Fees, Allowed Amounts, preferred provider reports, actuarial formulas, providers' personal information, and financial terms of this Contract.
- C. Confidential Information shall not include any information that:
 - 1. Is already known to the Party at the time of the disclosure (as evidenced by written documentation existing at that time);
 - 2. Is generally available to the public or becomes publicly known through no wrongful act of a Party; or
 - 3. Is received by a Party from a third-party who had a legal right to provide it (as evidenced by written documentation existing at that time).
- D. The Parties each will make all reasonable, necessary and appropriate efforts to safeguard each other's Confidential Information. Each Party will safeguard the other's Confidential Information to the same extent that it safeguards information relating to its own business, which in no event will be less than the safeguards that a reasonably prudent business would exercise under similar circumstances.
- E. Each Party agrees not to use, distribute or exploit each other's Confidential Information, in whole or in part, for its own benefit or that of any third party and will not disclose such Confidential Information to any other person or entity without each other's prior written consent. A Party shall be responsible for any breach of this Contract by its employees, authorized subcontractors, agents or representatives.
- F. Notwithstanding anything to the contrary in this Section, the Parties shall be permitted to disclose Confidential Information as required by order of a court of law, administrative agency, or other governmental body; provided, however, the Party shall provide reasonable advance written notice to the other Party to the extent allowed by law in order to allow that Party the opportunity to seek a protective order or otherwise limit such disclosure, and the disclosing Party shall reasonably cooperate with the other Party to limit any such disclosure or to seek a protective order. If a Party is nonetheless required to disclose the other Party's Confidential Information, said Party shall only disclose the minimum information necessary to respond to the legal request. Notwithstanding the foregoing, Delta Dental shall not be required to provide Contractor notice prior to responding to governmental agency subpoenas regarding potential provider fraud or abuse.

SECTION XI - RIGHTS AND REMEDIES

- A. In addition to the right of termination described in Section IX, Delta Dental shall have the following rights and remedies in the event Contractor fails to timely pay in full the Administrative Service Fees or reimburse Delta Dental for the Cost of Claims, subject to Contractor's right to cure pursuant to Section IX.B.:
 - 1. Delta Dental may retroactively terminate this Contract to the date it last received payment; and

2. Delta Dental may initiate proceedings to recover and collect all payments due and owing, as well as all costs associated with the collection proceedings including, but not limited to, attorneys' fees.
 3. Notwithstanding the foregoing, Delta Dental may immediately suspend payment of all Claims in the event that it does not receive timely payment of the Administrative Service Fees or reimbursement for the Cost of Claims.
- B. No claim, lawsuit or action, may be brought more than three years after the claim first arose.
- C. Either Party's failure to exercise any right or remedy contained herein shall not constitute a waiver of any future rights or remedies available to that Party.

SECTION XII - GENERAL PROVISIONS

- A. **Subrogation.** Delta Dental shall be subrogated to all of Contractor's rights with respect to any Claim(s). However, Delta Dental is not obligated to institute or become involved in any litigation concerning such Claim(s). If after six (6) months Delta Dental is unable recover through reasonable efforts, using its standard overpayment recovery processes, any amounts due and owing to Contractor, Delta Dental will provide Contractor with notice of any such unrecovered Claims. The decision to further pursue recovery of such Claims shall be within the sole discretion of Contractor and at Contractor's sole expense. Delta Dental will provide reasonable assistance to Contractor in any such recovery efforts, but in no event will Delta Dental be obligated to undertake any recovery litigation unless mutually agreed to by Delta Dental and Contractor. Delta Dental will remit to Contractor any applicable funds recovered from third parties, less any expenses it has incurred in its recovery efforts. Such funds shall be applied as a credit to Contractor's invoice(s). Contractor will assist Delta Dental as will be reasonably necessary for Delta Dental to carry out its duties under this provision. Delta Dental may assign or subcontract a portion of its duties under this provision of the Contract to others.
- B. **Right to Review Published Materials.** Contractor agrees not to publish or distribute any materials containing the logo, trademark, or business mark of Delta Dental, or containing a change in the benefits to be administered under this Contract, until Delta Dental reviews and, with respect to the use of Delta Dental's logo, trademark, or business mark, approves the materials. This provision does not apply to materials that Delta Dental has provided to Contractor for distribution.
- C. **Cooperation.** The Contractor shall provide Delta Dental with any information it may reasonably require to administer the Dental Plan or otherwise discharge its duties under this Contract.
- D. **Indemnification.**
1. Each Party agrees to defend, indemnify, and hold harmless the other Party and its directors, officers, affiliates, agents, and employees (who are acting in the course of their employment, but not as claimants) from any loss, cost, or expense (including reasonable attorney fees and court costs) ("Losses") resulting from or arising out of or in connection with the indemnifying Party's breach of this Contract, or any negligent act or omission of any of the indemnifying Party's directors, officers, agents or employees, unless liability for such act or omission is expressly assigned elsewhere in this Contract.
 2. The indemnifying Party shall provide prompt written notice of relevant information concerning any Losses to the indemnified Party. Reasonable assistance (at the indemnifying Party's expense) may be requested by the indemnified Party in connection with the defense of any Losses. Notwithstanding the foregoing:
 - a. The indemnified party shall permit the indemnifying Party to control the defense or settlement of the claim, suit or proceeding at the indemnifying party's expense;
 - b. The indemnified Party shall have the right to provide for its separate defense at its own expense;
 - c. Neither Party shall settle any Losses without the consent of the other Party, which consent shall not be unreasonably withheld. Any release obtained as a result of settlement must contain a release of all claims against the indemnified Party as well as its officers, directors and employees, and
 - d. The indemnification obligations of indemnifying Party hereunder shall not extend to Losses attributable to the negligence, intentional misconduct, or willful malfeasance of the indemnified Party.
- E. **Notice.** Any notice required or permitted to be given under this Contract will be considered given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the other Party at its last address of record.
- F. **Survival.** The following Sections shall survive expiration or early termination of this Contract: Section VIII. Payment; Section X. Confidentiality & Disclosure; Section XI. Rights and Remedies; and Section XII. General Provisions.
- G. **Internal Policies and Procedures.** Delta Dental has the right to amend its internal policies and procedures periodically and without notice to the Contractor to the extent the amendment does not affect the delivery of

benefits to Members. Delta Dental will provide advance written notice, to the extent possible, to Contractor of any amendment to Delta Dental's policies or procedures that affect the delivery of benefits to Members; if advance notice is not possible, Delta Dental will provide written notice as soon as possible after the amendment is adopted.

- H. **Third Party Beneficiaries.** This Contract will not confer any rights or remedies on any third-party, other than the Parties to this Contract and their respective successors and permitted assigns.
- I. **Assignment and Subcontracting.** Unless it has first obtained the written consent of the other Party, neither Party may assign this Contract or any of its rights or obligations under this Contract to any other person, except that Delta Dental may make assignments to its subsidiaries and affiliates without the prior written consent of the Contractor.
- J. **Integration.** This Contract constitutes the entire understanding between the Parties with respect to the subject matter of this Contract and supersedes any prior discussions, negotiations, agreements and understandings.
- K. **Force Majeure.** Unless otherwise stated in the Declarations Section of this Contract, neither Delta Dental (including its agents, directors, officers, and employees) nor Contractor shall be liable for delays in performance due to circumstances beyond their reasonable control. Each Party shall be excused from performance under this Contract and shall have no liability to the other Party for any period during which it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other Party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications, and such nonperformance shall not be a default under or grounds for termination of this Contract.
- L. **Applicable Law.** This Contract and the obligations of the Parties under this Contract will be governed by and construed in accordance with ERISA to the extent applicable. If it is determined by a court of competent jurisdiction that ERISA does not apply, the law of the State of Michigan will control.
- M. **Venue.** The Parties submit to the jurisdiction and venue of the Circuit Court of Ingham County, State of Michigan, or if original jurisdiction can be established in the United States District Court of Western Michigan.
- N. **Severability.** If any part of this Contract or an amendment of it is found by an arbitrator, court, or other authority to be illegal, void or not enforceable, all other portions of this Contract shall remain in full force and effect.
- O. **Counterparts.** This Contract may be executed in one or more counterparts, each of which will be deemed an original agreement, but all of which will be considered one instrument and will become a binding agreement when one or more counterparts have been signed by each of the Parties and delivered to the other. Electronic and/or fax signatures shall be accepted as original signatures.
- P. **Audits.** The Contractor shall have the right to audit Delta Dental's files, books, and records (both paper and electronic) pertaining to the administrative services provided under this Agreement. The Contractor will bear the entire cost of any such audits. The Contractor may assign this right to audit to an agent, provided the agent is a licensed firm and the audit is led by an individual who holds a nationally recognized audit accreditation. Delta Dental will allow the Contractor or the Contractor's agent to audit the work areas at which services under this Contract are performed, within 14 business days of receipt of a fully-signed confidentiality agreement. Where applicable, Delta Dental agrees to segregate the Contractor's records from third-party records in order to allow accurate assessment of Contractor-specific processes. Such audits will take place no more than once in a 12-month period, unless both the Contractor and Delta Dental mutually agree that there is reasonable cause to conduct an audit more frequently, in which case the Contractor will give 14 business days' written notice before such audit. The scope of any audit conducted under this provision must be mutually agreed upon, in writing, by both parties prior to the start of the audit. Notwithstanding the foregoing, Contractor shall not have the right to audit any information which Delta Dental, in its sole discretion, determines is proprietary. During the audit, if claims samples are selected using a financially stratified methodology, the results shall be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.
- Q. **Other Goods and Services.** From time to time, Delta Dental may offer or provide Members certain goods and services, including discounts on dental services provided by Participating Dentists in addition to the dental coverage (including without limitation toothbrushes, dental floss and other oral hygienic devices/products). Delta Dental also may arrange for third party vendors to provide goods and services at a discount to Members. Though Delta Dental may make the arrangements, the third party vendors are solely liable for providing the goods and services. Delta Dental shall not be responsible for providing or failing to provide the goods and services to Members. Further, Delta Dental shall not be liable to Members for negligent provision of the goods and services by third party vendors. Delta Dental reserves the right to terminate or change these goods or services at any time.



**Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 3636-3000, 3099
St. Clair County**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan - Delta Dental of Michigan

Benefit Year - January 1 through December 31

Covered Services -

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Periodontal Maintenance - cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Radiographs - X-rays	50%	50%	50%
Minor Restorative Services - fillings and crown repair	50%	50%	50%
Endodontic Services - root canals	50%	50%	50%
Periodontic Services - to treat gum disease	50%	50%	50%
Oral Surgery Services - extractions and dental surgery	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Other Basic Services - misc. services	50%	50%	50%
Relines and Repairs - to prosthetic appliances	50%	50%	50%
Major Services			
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable with no limitations.
- Space maintainers are payable once per area per lifetime for people age 15 and under.

- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per five-year period for first and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services except orthodontic services. \$1,500 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – None.

Waiting Period – Enrollees who are eligible for dental benefits are covered 30 days from date of hire.

Eligible People – All full-time employees of the county working at least 37.5 hours per week (in a CBA that allows for Int & Ext COB) who choose the dental plan (3000) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (3099).

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the date of termination.

Delta Dental PPOTM

Our national PPO program

Welcome!

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan. Delta Dental of Michigan is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 800-524-0149 or access our website at www.DeltaDentalMI.com.

You can easily verify your own Benefit, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalMI.com and selecting the link for our Consumer Toolkit®. The Consumer Toolkit will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

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Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

I. Delta Dental PPO Certificate

Delta Dental Plan of Michigan, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Enrollee. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and the Contractor.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Goran M. Jurkovic, CPA, CGMA
President and CEO
Delta Dental Plan of Michigan, Inc.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

The amount permitted under the applicable fee schedule for This Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year

The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year, unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and the Contractor.

Child(ren)

Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim

A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- ◆ For dentures and partial dentures, on the delivery dates;
- ◆ For crowns and bridgework, on the permanent cementation date;
- ◆ For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment

The percentage of the charge, if any, that you must pay for Covered Services.

Contractor

The employer, organization, group, or association sponsoring This Plan.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Member Plan

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

Delta Dental Premier® Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Member Plan.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- ◆ **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
- ◆ **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
- ◆ **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.
- ◆ **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Delta Dental Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Delta Dental Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists."**

Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dependent(s)

Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits

Enrollee

You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Maximum Approved Fee

The Maximum Approved Fee is the lowest of:

- ◆ The Submitted Amount
- ◆ The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- ◆ The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Member(s)

Any Enrollee or Dependent with coverage under This Plan.

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period

The period of time, as determined by the Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate

A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Special Enrollment Period

A period outside of the Open Enrollment Period in which you or your Dependent can obtain coverage under This Plan due to a qualifying life event.

Spouse

Your legal spouse.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Members pursuant to this Certificate and your Summary of Dental Plan Benefits.

III. Enrolling in This Plan

The Open Enrollment Period, if applicable, will be established by the Contractor and will occur on an annual basis. During the Open Enrollment Period, all eligible persons as defined in your Summary of Dental Plan Benefits may enroll in This Plan. You and/or your Dependents may not enroll in This Plan at any other time during the applicable Benefit Year except in the following instances:

- a. Newly hired or rehired employees (if applicable): You will be eligible to enroll on the date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Dental Plan Benefits.
- b. New Spouse: Your new Spouse will be eligible to enroll on the date of marriage.
- c. Newborn: Your newborn will be eligible to enroll on the date of birth.
- d. Legal adoptions or guardianships: Your newly adopted Child(ren) and/or the minor Child(ren) that you and/or your Spouse have guardianship over will be eligible to enroll on the date that the legal petition for adoption or guardianship becomes legally final, or the date on which the Child(ren) begins residing with the Enrollee and the Enrollee assumes responsibility for the Child(ren) while waiting for adoption or guardianship to become final.
- e. New Stepchild: Your new stepchild will be eligible to enroll on the date that the Child's natural parent becomes a Dependent.
- f. To the extent Contractor permits Dependents other than those defined in this Certificate to enroll in This Plan, such Dependents will be eligible to enroll on the date that they become an eligible Dependent. Any such additional Dependents permitted by Contractor shall be set forth in your Summary of Dental Plan Benefits.
- g. All others will be permitted on the date that Delta Dental approves in

writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Dependent.

IV. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.DeltaDentalMI.com or call 800-524-0149.

V. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at 800-524-0149.
3. After you receive your dental treatment, you or the dental office staff will file a Claim form, completing the information portion with:
 - a. The Enrollee's full name and address
 - b. The Enrollee's Member ID number
 - c. The name and date of birth of the person receiving dental care
 - d. The Contractor's name and number

Notice of Claim Forms

Delta Dental does not require special Claim forms. However, most dental offices have Claim forms available. Participating Dentists will fill out and submit your dental Claims for you.

Mail Claims and completed information requests to:

**Delta Dental
P.O. Box 9085
Farmington Hills, Michigan 48333-9085**

Pre-Treatment Estimate

A Pre-Treatment Estimate is not required to receive payment, but it allows Claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a Claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under This Plan are post-service Claims. All Claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a Claim is filed, Delta Dental will adjudicate it within 30 days of receiving it. If there is not enough information to adjudicate your Claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the Claim, and (d) inform you or your Dentist that the information must be received within 45 days or your Claim will be Denied if the services were performed by a Nonparticipating Dentist, or not chargeable to the Member if the services were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to adjudicate your Claim. If you or your Dentist does not supply the requested information, Delta Dental will deny your Claim. In such case, you will be responsible for all charges if the services were performed by a Nonparticipating Dentist. If the services were performed by a Participating Dentist, the services will not be chargeable to the Member. Once Delta Dental adjudicates your Claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Contractor, call Delta Dental's Customer Service department, toll-free, at 800-524-0149, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to designate the person you wish to appoint as your representative. Delta Dental will only recognize the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to your Contractor or call Delta Dental's Customer Service department, toll-free, at 800-

524-0149. You may also write to Delta Dental's Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing to Delta Dental, please include your name, the Contractor's name and number, the Enrollee's Member ID number, and your daytime telephone number.

VI. How Payment is Made

Delta Dental shall make payments for Covered Services in accordance with the type of plan selected by the Contractor. The type of plan selected will be identified on your Summary of Dental Plan Benefits.

Delta Dental PPO (Point-of-Service)

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the Nonparticipating Dentist Fee for Covered Services.

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Delta Dental PPO (Standard)

Regardless of your Dentist's participating status, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. If your Dentist is not a PPO Dentist, but is a Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Orthodontics

If This Plan includes orthodontics it will be identified on and paid as reflected in your Summary of Dental Plan Benefits.

Covered Services Requiring Multiple Visits

In the event a Covered Service requires more than one (1) visit with your Dentist, payment for the Covered Service will be rendered upon Completion Date.

VII. Benefit Categories

The Benefits covered by This Plan are set forth in your Summary of Dental Plan Benefits.

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.

7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered under the terms of this Certificate.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract between Delta Dental and the Contractor.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision abutments, attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
42. Myofunctional therapy.
43. Mounted case analyses.
44. Antigen or antibody testing for a public health related pathogen.
45. Any and all taxes applicable to the services.

46. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Caries risk assessment performed on a Member age 2 or under.
5. Local anesthesia.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy as an aid to the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
27. Full mouth debridement, when done on the same day as comprehensive evaluation.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.

31. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
32. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
33. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
34. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
35. Capture only images which are not associated with any interpretation or reporting.
36. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
37. Implant removal when performed within three (3) months of an implant/mini-implant on the same tooth by the same dentist or dental office.
38. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.
6. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age 8 and under.
10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restoration on the same tooth are also subject to this five-year limitation.
11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
14. Hard full or partial arch occlusal guards are payable once in a lifetime.
15. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over.
16. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36 month period.
17. Prosthodontic Services limitations:
 - a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
 - b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
 - c. A removable unilateral partial denture is payable once per quadrant in any 5 year period unless the loss of additional teeth requires the construction of a new appliance.

- d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.
 - e. A relined or the complete replacement of denture base material is payable once in any three-year period per appliance.
 - f. Implant removal is payable once per lifetime per tooth or area.
 - g. Implant maintenance is payable once per any twelve (12) month period.
 - h. Removal of a broken implant retaining screw is payable once in a 5 year period.
18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:
- a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.
 - b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
 - c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.
20. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily

provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

- a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
 - b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
 - d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
 - e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
 - f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
 - g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
 - h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
23. Maximum Payment:
- a. All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

25. Caries risk assessments are payable once in any 12-month period for Members age 3-18.
26. Assessments of salivary flow by measurement are payable once in any 36-month period.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
29. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five (5) applications per day.
30. Sealants are covered once per tooth per lifetime on first permanent molars for Members age 9 and under.
31. Sealants are covered once per lifetime on second permanent molars for members age 14 and under.
32. One cone beam CT is allowed within a twelve (12) month period except when performed for TMD treatment.
33. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e. to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a twelve (12) month period when done by the same dentist/dental office.
16. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same dentist/dental office.
17. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

IX. Coordination of Benefits

Coordination of Benefits (“COB”) applies to This Plan when a Member has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan’s Benefits are determined before or after another plan’s benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your Claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the Member to This Plan’s Enrollee, as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another plan that does not coordinate benefits, it will always be primary.

2. Enrollee v. Dependent Coverage

The plan that covers the Member as an Enrollee will be primary over a plan that covers the Member as a dependent. However, please note that if the Member is a Medicare beneficiary, federal law may reverse this order.

3. Children (Parents Divorced or Separated)

If a court decree makes one parent responsible for health care expenses, that parent’s plan is primary.

If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the Child’s health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

If neither of these rules applies, the order will be determined as follows:

- a. First, the plan of the parent with custody of the Child will be primary;
- b. Then, the plan of the spouse of the parent with custody of the Child will be primary;
- c. Next, the plan of the parent without custody of the Child will be primary; and
- d. Last, the plan of the spouse of the parent without custody of the Child will be primary.

4. Children and the Birthday Rule

The plan of the parent whose birthday is earliest in the calendar year is always primary for Children. For example, if your birthday is in

January and your spouse’s birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Laid Off or Retired Employees

The plan that covers the Member as a laid off or retired employee or as a dependent of a laid off or retired employee will be primary.

6. COBRA Coverage

The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA) will be primary.

7. Other Plans

If none of the rules above determines the order of benefits, the plan that has covered the Member for the longer period will be primary.

If the other plan does not have rule 5 and/or rule 6 (above) and decides the order of benefits differently from This Plan, This Plan may ignore either of those rules.

In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures for determining which plan is primary, unless prohibited by applicable law.

How Delta Dental Pays as Primary Plan

When Delta Dental is the primary plan, it will pay for Covered Services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan.

When Benefits are reduced as described above, each Benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person regarding the Claim being coordinated. Delta Dental need not tell or get the consent of any person to do this. Each person claiming Benefits

under This Plan must give Delta Dental any facts it needs to pay the Claim.

Facility of Payment

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

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

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, Delta Dental may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Member.

Payment includes the reasonable cash value of any benefits provided in the form of services.

X. Reconsideration and Claims Appeal Procedure

Reconsideration

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental’s Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you

can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

**Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916**

Please include your name and address, the Enrollee’s Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer’s decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person’s subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

XI. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- ◆ When the Contractor advises Delta Dental to terminate your coverage.
- ◆ On the first day of the month for which the Contractor has failed to pay Delta Dental.
- ◆ For fraud or misrepresentation in the submission of any Claim.
- ◆ For your Dependent, when they no longer qualify as a Dependent.
- ◆ For any other reason stated in the Contract between Delta Dental and the Contractor.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XII. Continuation of Coverage

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

1. Your employment, if applicable, ends for any reason other than your gross misconduct.
2. You do not qualify as an Enrollee as set forth in your Summary of Dental Plan Benefits.
3. You are divorced or legally separated.
4. You die.
5. Your Dependent is no longer a Dependent.
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XIII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide

payments or benefits for the Covered Services that were paid for by Delta Dental,

2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a Claim for such has not been received by

Delta Dental within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will deny that portion of the Claim that Delta Dental would have paid if the Claim had been timely submitted, and such denied portion of the Claim will not be chargeable to the Member. However, you will remain responsible for any applicable Deductible and/or Copayment. In the event that a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group Contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any

payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800-524-0147

Medical Examiners - Michigan Forensics, PLLC Addendum #1

Summary:

ATTACHMENTS:

	Description	Upload Date	Type
📎	Medical Examiners - Death Investigations_Memo	11/23/2021	Cover Memo
📎	03-01-21 Addendum 1 - Michigan Forensics - draft	11/23/2021	Cover Memo



COUNTY OF ST. CLAIR

OFFICE OF THE ADMINISTRATOR/CONTROLLER



Karry Hepting, CPA
Administrator/Controller

MEMO

To: Board of Commissioners

From: Karry Hepting

Date: November 22, 2021

Re: Death Investigations

Historically the County has handled Medical Examiner operations and death scene investigations differently than most counties. Death scene investigations historically have been completed by law enforcement staff, with follow up investigations handled by Medical Examiner staff. The Sheriff's Department along with local police agencies had numerous officers trained to perform these specialized types of investigations. Those officers volunteered to receive this extra training to perform death scene investigations. As these employees retire, there are few officers remaining to complete these scene investigations. Starting in 2012, we began to add staff to the ME's office to assist with these investigations. Currently law enforcement covers daytime investigations, while ME staff cover the evening investigations.

Over the past year, police agencies have expressed concerns regarding the lack of trained staff to complete investigations along with the amount of officer time required for investigations. An officer may be required to stay at a death scene for several hours making them unavailable to handle other law enforcement calls. At the end of September, I met with representatives from the Sheriff's office along with the majority of the Police Chiefs to discuss their concerns and possible solutions. I then met with Dr. Spitz to review the concerns and at that time asked for a proposal for Michigan Forensics to conduct all death investigations.

The amount of death scene investigations for the last several years are as follows:

- 2019 403
- 2020 541
- 2021 630 (estimated based on 526 through October)

Based on discussions with the Sheriff, the average amount of time spent is approximately 2.5 hours at each scene and it may involve 1 or 2 deputies. Assuming half of the investigations occur during the day hours, an estimated 315 scenes or 1,575 hours of officer time will be spent on scene investigations in 2021.

Michigan Forensics has proposed an amount of \$119,800 to cover all daytime investigations or an additional 4,380 hours per year of coverage. As a cost comparison, the cost of one full time deputy with full fringes for 2022 equates to \$117,924 for 2,080 hours of coverage. As you can see from the figures provided, the number of scene investigations have been and continue to increase each year. This will further increase time required by not only our Sheriff's office, but also all local police agencies that have trained staff to conduct death investigations. With fewer officers trained to do investigations, delays in response time may occur as those officers may be handling law enforcement calls. EMS must remain on the scene until an officer or medical examiner staff arrive. This ties up an ambulance and adds additional pressure to an organization experiencing a staff shortage. The proposed contract with Michigan Forensics will establish mutually acceptable response times. If approved a follow-up meeting with all stakeholders will be arranged prior to year-end to address all concerns and establish a protocol and response times going forward.

It is my recommendation you approve the contract with Michigan Forensics to handle all death investigations beginning January 1, 2022. The additional funds needed to cover the contract cost will be added to the first budget adjustment of 2022.

COUNTY OF ST. CLAIR, MICHIGAN
Medical Examiner's Office

ADDENDUM #1

Contract Expiration Date: December 31, 2023

This "Agreement" is made between the COUNTY OF ST. CLAIR, a Michigan Constitutional Corporation, hereinafter called "County", and the "Contractor" as further described in the following Table. In this Contract, either Contractor or the County may also be referred to individually as a "Party" or jointly as the "Parties".

COUNTY OF ST. CLAIR, MICHIGAN (Medical Examiner's Office) 200 Grand River Port Huron, MI 48060 (herein, the "County")	Michigan Forensics, PLLC 34051 S. Gratiot, Suite 202 Clinton Township MI 48035 (herein, the "Michigan Forensics")
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THIS ADDENDUM made and entered into this ____ day of December 2021 by and between the **COUNTY OF ST. CLAIR, MICHIGAN** and **MICHIGAN FORENSICS, PLLC** to amend the original agreement entered into on January 7, 2021 with a term of February 1, 2021 through December 31, 2023. The effective date of this Addendum shall be January 1, 2022.

The Parties, hereby, agree to amend contract for services, as outlined below:

Remove and Replace Section 2 Definitions (c) Medical Examiners Services with subsection (b) as follows – The administration of the St. Clair County Medical Examiner's Office, including an Annual Report prepared and submitted to the Board of Commissioners within 6 months of fiscal year end.

Remove and Replace Section 2 Definitions (c) Medical Examiners Services with subsection (f) as follows – Provide death scene investigations 24 hours per day 7 days per week for the duration of the contract term, as well as 24-hour on-call investigator coverage for police investigation reports and for reporting of hospital and hospice deaths. Response times will be mutually agreed upon by County and Michigan Forensics.

Add Section 5 Performance of Services (h) – Michigan Forensics shall offer private autopsies for the Medical Examiner's Office in accordance with the approved fee schedule adopted by the Board of Commissioners. Revenue shall be deposited with the County and no supplemental pathologist fees shall be distributed.

Amend Section 7 Compensation to reflect the removal of the employee lease and additional hours of death scene investigation for 2022 and 2023. The updated annual compensation schedule to Michigan Forensics shall be as follows:

2022		2023	
Base	\$555,274.28	Base	\$571,932.50
HC&R	-\$29,150.00	HC&R	-\$29,150.00
Additional Hours	\$119,800.00	Additional Hours	\$123,394.00
	\$645,924.28		\$666,176.50

All other terms, conditions and sections shall remain in full effect.

FOR MICHIGAN FORENSICS, PLLC:

BY: _____
Daniel Spitz, M.D., Authorized Agent

DATE: _____

FOR THE COUNTY:

BY: _____

DATE: _____

Karry A. Hepting, Administrator/Controller

County Clerk Manning Table Change/Addition

Summary:

ATTACHMENTS:

	Description	Upload Date	Type
📎	Clerk Manning Table change request	11/19/2021	Cover Memo
📎	Clerk Manning Table 11-18-21	11/19/2021	Cover Memo
📎	DBarbour Memo to Board Reclassification Clerk II to Clerk III DeBoyer Nov 2021	11/19/2021	Cover Memo



COUNTY OF ST. CLAIR

St. Clair County Clerk/Register of Deeds
St. Clair County Clerk, Chief Deputy
201 McMorran Blvd. Room 1100
Port Huron, MI 48060



Jay M. DeBoyer
Angie Waters
Phone: 810-985-2200
Fax: 810-985-2241

St Clair County Board of Commissioners
200 Grand River Ave
Port Huron, MI 48060

11/08/2021

Commissioners

I am requesting two changes to the manning table of the County Clerk's office.

1. Currently I have a Court Clerk II position that I would like to change to a Court Clerk III position as the current individual is executing the duties of a Court Clerk III. I would like to make this effective immediately.
2. I am requesting the addition of one, full-time Court Clerk III position add to the County Clerks manning table effective at the beginning of the 2022 year.

I have provided this information to Human Resources and to Administration. Administration has provided the financial impact of these two requests to you. Should you have any further questions of concerns please contact me.

Sincerely

Jay M. DeBoyer
St. Clair County Clerk/Register of Deeds



COUNTY OF ST. CLAIR



Office of the Administrator/Controller

KARRY HEPTING
Administrator/Controller

MEMO

To: Board of Commissioners

From: Dena Alderdyce, Finance Director

Date: November 18, 2021

Re: County Clerk Manning Table Change/Addition

The County Clerk is asking the Board to approve a manning table change that would convert a full time Deputy Clerk II to a Deputy Clerk III. This change will cost an additional \$10,981 annually at the top step with full fringe benefits.

The County Clerk is also asking to add one full time Clerk III position to their manning table starting 1/1/2022. The total cost of the position with full fringe benefits and top step of the pay scale is \$72,187. However, 80% of this position would be paid from the Clerk's Concealed Pistol License (CPL) fund and the other 20% would come from the General fund.

In order to cover the cost in the general fund, the Clerk will be eliminating one of the vacant part time Deputy Clerk I positions. The CPL fund has sufficient funds to pay 80% of the position as well.

	<u>General Fund</u>	<u>CPL Fund</u>
Deputy Clerk II to Deputy Clerk III	\$10,981	
Add 1 FT Deputy Clerk III	\$14,437	\$57,750
Remove 1 PT Deputy Clerk I	(\$25,418)	
Total change	\$0	\$57,750

The above mentioned changes will be budget neutral and no additional appropriation will be needed from the general fund.

We recommend the Board approve the manning table changes at the December 9, 2021 board meeting.



COUNTY OF ST. CLAIR



MEMO

To: Board of Commissioners

From: Diane Barbour, Director of Human Resources

Date: June 17, 2021

Subject: Reclassification Request-County Clerk Department
☒ COMPLIANCE WITH HUMAN RESOURCE POLICIES

Background:

The County Clerk/Register of Deeds, Jay Deboyer, is requesting a reclassification from a Deputy Clerk II to a Deputy Clerk III within the County Clerk's department. The position has increased in responsibilities and skill set through turnover and the assumption of additional, more advance duties. The current level of performance includes training new staff, assisting with election activities, attending court hearings and processing jury system items. These responsibilities are typically a more advanced level and classified within the Clerk III job framework.

For this reason, I support the reclassification of the Deputy Clerk II to a Deputy Clerk III at a wage range of I-F as requested.

Thank you,

Diane Barbour
Director-Human Resources

Resolution 21-28 Establishing Per Diems for Boards and Commissions - FINAL ACTION

Summary:

ATTACHMENTS:

	Description	Upload Date	Type
	Resolution 21-28 Establishing Per Diems for Boards and Commissions	11/23/2021	Cover Memo

RESOLUTION 21-28
RELATIVE TO “PER DIEMS”
FOR BOARDS AND COMMISSIONS

WHEREAS, it is the duty of the St. Clair County Board of Commissioners annually, to determine the “Per Diems” to be paid to members of Boards and Commissions in cases where no provision is made by Board action or statute; and

WHEREAS, it is the opinion of the St. Clair County Board of Commissioners, that in such cases the “Per Diem” to be paid to members of various appointed Boards and Commissioners should be \$30.00 per day, in addition to such mileage allowance for travel, as the Board of Commissioners from time to time may determine.

NOW THEREFORE, BE IT RESOLVED:

- 1) That for the year 2022, the “Per Diem” to be paid to members of Boards and Commissions appointed by the St. Clair County Board of Commissioners, shall be \$30.00 per day, plus such mileage allowance for travel as the Board of Commissioners from time to time may determine.
- 2) That such payments shall be limited to those Boards and Commissions for which the payment of “Per Diem” is specifically allowed by statute and not otherwise prohibited.
- 3) All resolutions and parts of resolutions, insofar as the same conflict with the provisions of this resolution be, and the same are hereby rescinded

DATED: December 2, 2021

Reviewed and Approved As To Form By: _____

Gary A. Fletcher
County Corporation Counsel
1411 Third Street Suite F
Port Huron, MI 48060

Resolution 21-29 Elected Officials Wages for 2022 - FINAL ACTION

Summary:

ATTACHMENTS:

Description	Upload Date	Type
📎 Resolution 21-29 Elected Officials Wages for 2022	11/23/2021	Cover Memo

RESOLUTION 21-29
ESTABLISHING SALARIES
OF SPECIFIC COUNTY ELECTED AND NON-ELECTED OFFICERS FOR 2022

WHEREAS, the St. Clair County Board of Commissioners has responsibility to establish the salary levels of all County Elected and Non-elected Officers; and

WHEREAS, the St. Clair County Board of Commissioners has reviewed and evaluated the compensation of said Officers and recommends that said compensation is appropriate.

NOW, THEREFORE, BE IT RESOLVED:

- 1) That the salary levels of County Elected and Non-elected Officers, be, and the same hereby are established as specified as follows.

<u>Officer</u>	<u>Annual Salary</u>
Surveyor	\$8,779
Drain Commissioner	\$82,936
Treasurer	\$88,271
Clerk/Register	\$90,844
Prosecuting Attorney	\$139,485
Sheriff	\$119,233
Magistrates	\$60.11 per hour

- 3) That the salary and benefits assigned herein to each classification shall be for one (1) year (2022) effective January 1, 2022.
- 4) All resolutions and parts of resolutions, insofar as the same conflict with the provisions of this resolution be, and the same are hereby rescinded.

Dated: December 9, 2021

Reviewed and Approved as to Form by:

Gary A. Fletcher
County Corporation Counsel
1411 Third Street Suite F
Port Huron MI 48060

Resolution 21-30 Establishing Wages for CANUE 2022 - FINAL ACTION

Summary:

ATTACHMENTS:

	Description	Upload Date	Type
📎	Resolution 21-30 Establishing Wages for CANUE 2022	11/23/2021	Cover Memo
📎	2022 County Wage Scale	11/23/2021	Cover Memo

RESOLUTION 21-30

APPROVING ANNUAL WAGE ADJUSTMENTS FOR THE COUNTY ASSOCIATION OF NON-UNION EMPLOYEES (CANUE)

WHEREAS, the employees of the County Association of Non-Union Employees hereafter called CANUE are employees with no affiliation with or membership in a labor organization or recognized as an affiliated group of employees with the right and ability to collectively bargain with the County of St. Clair; and

WHEREAS, the St. Clair County Board of Commissioners has exclusive and unilateral right and authority to establish the compensation plan for determining the annual wage and salary compensation of employees of CANUE; and

WHEREAS, the St. Clair County Board of Commissioners does hereby exercise its exclusive and unilateral right to establish the compensation plan for determining the annual wage and salary compensation of employees of CANUE; and

NOW THEREFORE, BE IT RESOLVED, that the Exempt Employee Compensation Structure (Attached Exhibit "A") for the period January 1, 2022 through December 31, 2022 is hereby approved and adopted. The 2022 CANUE compensation structure includes a 2% increase.

Dated: December 2, 2021

Reviewed and Approved by:

Board of Commissioners:

GARY FLETCHER
County Corporation Counsel
1411 Third Street Suite F
Port Huron, MI 48060

2022 County Wage Structure

2% increase											
			STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6	STEP 7	STEP 8	Wage Range
Group I: Office Professionals/General											
	A		24,127	25,091	26,094	27,138	28,225	29,353	30,526	31,748	A
	AA		25,091	26,094	27,138	28,225	29,353	30,526	31,748	33,018	AA
	B		26,094	27,138	28,225	29,353	30,526	31,748	33,018	34,338	B
	BB		27,138	28,225	29,353	30,526	31,748	33,018	34,338	35,713	BB
	C		28,225	29,353	30,526	31,748	33,018	34,338	35,713	37,140	C
	CC		29,353	30,526	31,748	33,018	34,338	35,713	37,140	38,627	CC
	D		30,526	31,748	33,018	34,338	35,713	37,140	38,627	40,171	D
	DD		31,748	33,018	34,338	35,713	37,140	38,627	40,171	41,778	DD
	E		33,018	34,338	35,713	37,140	38,627	40,171	41,778	43,450	E
	EE		34,338	35,713	37,140	38,627	40,171	41,778	43,450	45,188	EE
	F		35,713	37,140	38,627	40,171	41,778	43,450	45,188	46,995	F
	FF		37,140	38,627	40,171	41,778	43,450	45,188	46,995	48,875	FF
	G		38,627	40,171	41,778	43,450	45,188	46,995	48,875	50,830	G
Group II: Professional/Technical											
	A		29,353	30,526	31,748	33,018	34,338	35,713	37,140	38,627	A
	AA		30,526	31,748	33,018	34,338	35,713	37,140	38,627	40,171	AA
	B		31,748	33,018	34,338	35,713	37,140	38,627	40,171	41,778	B
	BB		33,018	34,338	35,713	37,140	38,627	40,171	41,778	43,450	BB
	C		34,338	35,713	37,140	38,627	40,171	41,778	43,450	45,188	C
	CC		35,713	37,140	38,627	40,171	41,778	43,450	45,188	46,995	CC
	D		37,140	38,627	40,171	41,778	43,450	45,188	46,995	48,875	D
	DD		38,627	40,171	41,778	43,450	45,188	46,995	48,875	50,830	DD
	E		40,171	41,778	43,450	45,188	46,995	48,875	50,830	52,863	E
	EE		41,778	43,450	45,188	46,995	48,875	50,830	52,863	54,978	EE
	F		43,450	45,188	46,995	48,875	50,830	52,863	54,978	57,176	F
	FF		45,188	46,995	48,875	50,830	52,863	54,978	57,176	59,464	FF
	G		46,995	48,875	50,830	52,863	54,978	57,176	59,464	61,843	G
	GG		48,875	50,830	52,863	54,978	57,176	59,464	61,843	64,315	GG
	H		50,830	52,863	54,978	57,176	59,464	61,843	64,315	66,889	H
	HH		52,863	54,978	57,176	59,464	61,843	64,315	66,889	69,563	HH
	I		54,978	57,176	59,464	61,843	64,315	66,889	69,563	72,346	I
	II		57,176	59,464	61,843	64,315	66,889	69,563	72,346	75,241	II
	J		59,464	61,843	64,315	66,889	69,563	72,346	75,241	78,251	J
	JJ		61,843	64,315	66,889	69,563	72,346	75,241	78,251	81,381	JJ
	K		64,315	66,889	69,563	72,346	75,241	78,251	81,381	84,635	K
	KK		66,889	69,563	72,346	75,241	78,251	81,381	84,635	88,021	KK
	L		69,563	72,346	75,241	78,251	81,381	84,635	88,021	91,541	L
	LL		72,346	75,241	78,251	81,381	84,635	88,021	91,541	95,203	LL
	M		75,241	78,251	81,381	84,635	88,021	91,541	95,203	99,011	M
	MM		78,251	81,381	84,635	88,021	91,541	95,203	99,011	102,973	MM
	N		81,381	84,635	88,021	91,541	95,203	99,011	102,973	107,090	N
	NN		84,635	88,021	91,541	95,203	99,011	102,973	107,090	111,375	NN
Group III: Division Heads/Supervisors											
	A		37,140	38,627	40,171	41,778	43,450	45,188	46,995	48,875	A
	AA		38,627	40,171	41,778	43,450	45,188	46,995	48,875	50,830	AA
	B		40,171	41,778	43,450	45,188	46,995	48,875	50,830	52,863	B
	BB		41,778	43,450	45,188	46,995	48,875	50,830	52,863	54,978	BB
	C		43,450	45,188	46,995	48,875	50,830	52,863	54,978	57,176	C
	CC		45,188	46,995	48,875	50,830	52,863	54,978	57,176	59,464	CC
	D		46,995	48,875	50,830	52,863	54,978	57,176	59,464	61,843	D
	DD		48,875	50,830	52,863	54,978	57,176	59,464	61,843	64,315	DD
	E		50,830	52,863	54,978	57,176	59,464	61,843	64,315	66,889	E
	EE		52,863	54,978	57,176	59,464	61,843	64,315	66,889	69,563	EE
	F		54,978	57,176	59,464	61,843	64,315	66,889	69,563	72,346	F
	FF		57,176	59,464	61,843	64,315	66,889	69,563	72,346	75,241	FF

	G		59,464	61,843	64,315	66,889	69,563	72,346	75,241	78,251	G
	GG		61,843	64,315	66,889	69,563	72,346	75,241	78,251	81,381	GG
	H		64,315	66,889	69,563	72,346	75,241	78,251	81,381	84,635	H
	HH		66,889	69,563	72,346	75,241	78,251	81,381	84,635	88,021	HH
	I		69,563	72,346	75,241	78,251	81,381	84,635	88,021	91,541	I
	II		72,346	75,241	78,251	81,381	84,635	88,021	91,541	95,203	II
	J		75,241	78,251	81,381	84,635	88,021	91,541	95,203	99,011	J
	JJ		78,251	81,381	84,635	88,021	91,541	95,203	99,011	102,973	JJ
	K		81,381	84,635	88,021	91,541	95,203	99,011	102,973	107,090	K
	KK		84,635	88,021	91,541	95,203	99,011	102,973	107,090	111,375	KK
	L		88,021	91,541	95,203	99,011	102,973	107,090	111,375	115,829	L
	LL		91,541	95,203	99,011	102,973	107,090	111,375	115,829	120,463	LL
Group IV: Department Heads											
	A		40,171	41,778	43,450	45,188	46,995	48,875	50,830	52,863	A
	AA		41,778	43,450	45,188	46,995	48,875	50,830	52,863	54,978	AA
	B		43,450	45,188	46,995	48,875	50,830	52,863	54,978	57,176	B
	BB		45,188	46,995	48,875	50,830	52,863	54,978	57,176	59,464	BB
	C		46,995	48,875	50,830	52,863	54,978	57,176	59,464	61,843	C
	CC		48,875	50,830	52,863	54,978	57,176	59,464	61,843	64,315	CC
	D		50,830	52,863	54,978	57,176	59,464	61,843	64,315	66,889	D
	DD		52,863	54,978	57,176	59,464	61,843	64,315	66,889	69,563	DD
	E		54,978	57,176	59,464	61,843	64,315	66,889	69,563	72,346	E
	EE		57,176	59,464	61,843	64,315	66,889	69,563	72,346	75,241	EE
	F		59,464	61,843	64,315	66,889	69,563	72,346	75,241	78,251	F
	FF		61,843	64,315	66,889	69,563	72,346	75,241	78,251	81,381	FF
	G		64,315	66,889	69,563	72,346	75,241	78,251	81,381	84,635	G
	GG		66,889	69,563	72,346	75,241	78,251	81,381	84,635	88,021	GG
	H		69,563	72,346	75,241	78,251	81,381	84,635	88,021	91,541	H
	HH		72,346	75,241	78,251	81,381	84,635	88,021	91,541	95,203	HH
	I		75,241	78,251	81,381	84,635	88,021	91,541	95,203	99,011	I
	II		78,251	81,381	84,635	88,021	91,541	95,203	99,011	102,973	II
	J		81,381	84,635	88,021	91,541	95,203	99,011	102,973	107,090	J
	JJ		84,635	88,021	91,541	95,203	99,011	102,973	107,090	111,375	JJ
	K		88,021	91,541	95,203	99,011	102,973	107,090	111,375	115,829	K
	KK		91,541	95,203	99,011	102,973	107,090	111,375	115,829	120,463	KK
	L		95,203	99,011	102,973	107,090	111,375	115,829	120,463	125,281	L
	LL		99,011	102,973	107,090	111,375	115,829	120,463	125,281	130,292	LL
	M		102,973	107,090	111,375	115,829	120,463	125,281	130,292	135,505	M
	MM		107,090	111,375	115,829	120,463	125,281	130,292	135,505	140,924	MM
	N		111,375	115,829	120,463	125,281	130,292	135,505	140,924	146,561	N
	NN		115,829	120,463	125,281	130,292	135,505	140,924	146,561	152,424	NN
	O		120,463	125,281	130,292	135,505	140,924	146,561	152,424	158,521	O
	OO		125,281	130,292	135,505	140,924	146,561	152,424	158,521	164,861	OO
											12/1/2020

Resolution 21-31 80_20 Cost Sharing Model Adoption - FINAL ACTION

Summary:

ATTACHMENTS:

	Description	Upload Date	Type
	Resolution 21-31 80_20 Cost Sharing Model adoption	11/23/2021	Cover Memo

Resolution 21-31

RESOLUTION TO ADOPT THE 80/20 COST SHARING MODEL AS SET FORTH IN THE PUBLICALLY FUNDED HEALTH INSURANCE CONTRIBUTION ACT NO. 152 OF 2011

Whereas, on September 27, 2011 the Publicly Funded Health Insurance Contribution Act, Act No. 152 of the Public Acts of Michigan of 2011 (Act 152), became effective in the State of Michigan; and

Whereas, pursuant to Act 152, Communities are given four options for complying with the requirements of the Act, depending on the impact of the Act on the employees of each public employer; and

Whereas, the four options set forth in Act 152 are as follows:

1. Apply the Hard Cap (capped dollar amount each government employer may pay towards an employee's healthcare costs);
2. Adopt by majority vote the 80%/20% cost-sharing model;
3. Elect not to follow the statute/noncompliance;
4. Opt out of the cost-sharing model as set forth in the bill and revisit it prior to the next plan year.

Whereas, the County of St. Clair Board of Commissions has determined it will adopt the 80/20 cost sharing model as its choice of compliance obligations under Act 152.

Now, Therefore, Be it resolved that:

1. To comply with the requirements of the Publicly Funded Health Insurance Contribution Act, Act No. 152 of 2011, the St. Clair County Board of Commissioners hereby adopts the 80/20 cost sharing formula as set forth in this Act.
2. All resolutions and parts of resolutions, insofar as they conflict with the provisions of this resolution are hereby rescinded.

Dated: December 2, 2021

Reviewed and Approved by:

Gary A. Fletcher
Corporation Counsel
1411 Third Street Suite F
Port Huron, MI 48060

