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GROUP DENTAL SERVICES CONTRACT

This Contract is made this _____ day of _____, 20_____, and is between **THE DENTAL NETWORK, INC.** (hereinafter referred to as "**PLAN**"), and _____ (hereinafter referred to as "**GROUP**").

Plan Number: _____ Effective Date: _____

Annual Termination Date: _____

Term: This Contract will have a Term of one (1) year (the "**Term**") and will be automatically renewed under identical terms from year-to-year, unless notice of termination is given by the PLAN at least thirty (30) days prior to any anniversary of this Contract (the "**Annual Termination Date**").

Cost for Services:

Tiers:

Covered Employee Only:	$ _____ / month
Covered Employee and Child:	$ _____ / month
Covered Employee and Spouse/Partner:	$ _____ / month
Covered Employee and Family:	$ _____ / month

In consideration of the application of the GROUP and of the payment of the Cost for Services as provided herein, the PLAN accepts such application and agrees to provide benefits under the terms of this Contract.

1. DEFINITIONS

A. ‘‘Approved Specialist” shall be a licensed specialized dentist who is board eligible, board qualified, or board certified in one of the specialty areas of periodontics, oral surgery, orthodontics, endodontics, and pedodontics and whose office has executed a contract with the PLAN.

B. “Cost for Services” shall mean amounts payable on a regular prepayment basis by or for the Covered Employee to the PLAN.

C. “Coverage Period” shall mean the month for which the Cost for Services has been prepaid by the Group for each Covered Employee and Dependent

D. “Covered Employee” shall mean an eligible employee, as defined, of the Group, who has enrolled for this coverage and who has paid the Cost for Services of the PLAN prior to the period of coverage, including payment for Dependents as hereinafter defined.

E. “Covered Employee Copayments” shall mean the cost of dental services to be paid by the covered Employee directly to the Participating DENTIST. See enclosed Schedule of Benefits and Copayments.

F. “Dependents” shall mean the lawful spouse of a Covered Employee and/or unmarried children of the Covered Employee from and after birth to age twenty-six (26). A legally adopted child of the Covered Employee and/or his spouse shall be treated as a child of the Covered Employee and/or his spouse for purposes of this Contract. Upon the attainment of age twenty-six (26) (the “PLAN Termination Age”), coverage as a Dependent shall be extended if the child is and continues to be both (1) incapable of self-sustaining employment by reason of mental or physical incapacity and (2) chiefly dependent upon the Covered Employee for support and maintenance, provided proof of such incapacity and dependency is furnished to PLAN by Covered Employee within thirty-one (31) days of the child’s attainment of PLAN Termination Age and subsequently as may be required by the PLAN, but not more often than annually after the two (2) year period following the child’s attainment of PLAN Termination Age. The Cost for Services for continuation of coverage of the incapacitated child shall be at the Dependent child rate, until such time as the coverage of the Covered Employee upon whom the child is dependent terminates.

G. “Eligible Employee” shall mean an employee of the Group who satisfies the requirements in the Group Application form.

H. “Group” shall mean the organization or employing unit with which the Covered Employee is associated and which has executed the Group Dental Services Contract.

I. “Participating DENTISTS” shall mean those licensed DENTISTS who have contracted with the PLAN to provide dental services to Covered Employees and Dependents under the PLAN and whose names appear on the list of Participating DENTISTS. The Participating DENTISTS are independent contractors, and are not employees or agents of the PLAN.

J. “Personal Participating DENTIST’’ shall mean the one Participating DENTIST selected by the Covered Employee and Dependents from the list of Participating DENTISTS, indicated on the completed Group Enrollment Form, and whose name appears on the Covered Employee’s Membership Identification Card.

2. ELIGIBILITY FOR BENEFITS

A. All Eligible Employees and their Dependents as defined in Section 1.F., who have enrolled in the PLAN and paid the appropriate Cost for Services on or before the twentieth (20^{th}) day of the month, shall be eligible for benefits commencing on the first (1^{st}) day of the following month, subject to the

terms of Section 4, B below. Coverage for a newly acquired spouse commences on the date of marriage. Coverage for newly acquired Dependent children, including children who are new born and/or legally adopted, commences on date of birth or date of court approved adoption. Court ordered coverage for children commences on the effective date of the court order as well as coverage for the eligible Employee if not already covered.

B. All Covered Employees and their Dependents become eligible for services on the Effective Date indicated on their Membership Identification Card, which will be the date determined from the terms of Section 2, A above.

C. If a parent eligible for family members' coverage is required under a "Qualified Medical Support Order," to provide health insurance coverage for a child, the PLAN:

1. Shall allow the insuring parent to enroll in family members' coverage and include the child in that coverage regardless of enrollment period restrictions;

2. If the insuring parent is enrolled in health insurance coverage but does not include the child in the enrollment, the PLAN shall:

   a. allow the noninsuring parent, child support enforcement agency, or Department of Health and Mental Hygiene to apply for enrollment on behalf of the child; and

   b. include the child in the coverage regardless of enrollment period restrictions; and

3. The PLAN may not terminate health insurance coverage for the child unless written evidence is provided to the entity that:

   a. the order is no longer in effect;

   b. the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;

   c. the GROUP has eliminated family members' coverage for all of its employees; or

   d. the GROUP no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the GROUP's plan for postemployment health insurance coverage for dependents.

4. Notwithstanding any other provision of this article, the PLAN may not deny enrollment of a child under the health insurance coverage of an insuring parent because the child:

   a. was born out of wedlock;

   b. is not claimed as a dependent on the insuring parent's federal income tax return;

   c. does not reside with the insuring parent or in the service area of the PLAN, or

   d. is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

5. If a child has health insurance coverage through an insuring parent, the PLAN shall:

   a. provide to the noninsuring parent membership cards, claims forms, and any other information necessary for the child to obtain benefits through the health insurance

coverage; and process the claims forms and make appropriate payment to the noninsuring parent, health care provider, or Department of Health and Mental Hygiene if the noninsuring parent incurs expenses for health care provided to the child.

6. Within 20 business days after receipt of a medical support notice from an employer, the PLAN:

   a. shall determine whether the medical support notice contains:

      i. the employee's name and mailing address; and

      ii. the child's name and the child's mailing address or the address of a substituted official;

   b. if the medical support notice does not contain the information described in paragraph 6.a of this subsection, shall complete and forward the appropriate part of the medical support notice to the issuing child support enforcement agency advising that the medical support notice does not constitute a qualified medical child support order; and

   c. if the medical support notice contains the information described in paragraph 6.a of this subsection, shall comply with the following requirements:

      i. determine the child's eligibility for enrollment;

      ii. complete and send the appropriate part of the medical support notice to the employer and the child support enforcement administration;

      iii. enroll the child if the child is eligible for enrollment, subject to subsection 7 of this section;

      iv. send to the employee, child, and custodial parent of the child a written notice that explains that the coverage of the child is or will become available to the child; and

      v. send to the custodial parent of the child a written description of:

         1) the health insurance coverage;

         2) the effective date of coverage;

         3) the employee's cost for the health insurance coverage; and

         4) if not already provided:

            a) a summary plan description;

            b) any forms, documents, or information necessary to effectuate coverage; and

            c) any information necessary to submit claims for benefits.

7. If the employee's eligibility for health insurance coverage is subject to a waiting period that has not been completed, the PLAN:

   a. shall complete and send the appropriate part of the medical support notice to the GROUP and the issuing child support agency within 20 business days after receipt of the medical support notice from the GROUP; and

b. on the employee's satisfaction of the waiting period, shall complete enrollment of the child in accordance with this section and send the notice and information required under subsection 6.c of this section.

8. If the employee's health insurance plan requires that the employee be enrolled in order for the child to be enrolled and the employee is not currently enrolled, the carrier shall enroll both the employee and the child, without regard to enrollment period restrictions, within the time period specified in subsection 6 of this section.

9. If a child is eligible for enrollment, the PLAN shall complete the enrollment without regard to enrollment period restrictions, within the time periods specified in subsections 6 and 7 of this section.

10. The requirement for notification of the child may be satisfied by notifying the custodial parent if the child and the custodial parent live at the same address.

3. TERMINATION OR CANCELLATION

Coverage shall cease as follows:

A. On the date of expiration of the Coverage Period for which the last payment of Cost for Services was made, but in no event shall coverage cease earlier than the last day of the grace period. Coverage will remain in force during a thirty (30) day grace period allowed for late payment of Cost for Services.

B. For Dependent children, upon the next Cost for Services payment due date following the date the Dependent ceases to satisfy the requirements of a Dependent as specified in Section 1.F.

C. Notwithstanding any limiting age, any unmarried child covered under the Contract as a Dependent of a Covered Employee who is chiefly dependent for support upon the Covered Employee, and who, at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that commenced prior to the child's attaining the limiting age, shall continue to be covered under the Contract while remaining so dependent, unmarried, and mentally or physically incapacitated, until the coverage on the Covered Employee upon whom the child is dependent terminates.

D. For Dependent spouses, upon becoming divorced or legally separated from Covered Employee, coverage will cease at the end of the Coverage Period during which the event occurs.

E. If, after reasonable efforts to establish and maintain a satisfactory dentist-patient relationship, the "Personal Participating DENTIST" is unable to do so, PLAN reserves the right to transfer the Covered Employee and/or a Dependent, as the case may be, to a second "Personal Participating DENTIST" of their choice. If the second "Personal Participating DENTIST" is also unable to establish a satisfactory dentist-patient relationship, PLAN reserves the right to terminate the membership of said Covered Employee and/or Dependent(s). In a case involving only a Dependent, only the Dependent's coverage will be terminated. A thirty (30) day written notice of termination and a pro-rata refund of unearned Cost for Services will be given to the Covered Employee or credited to the Group.

4. COST FOR SERVICES AND COVERED EMPLOYEE COPAYMENTS

A. All Cost for Services are payable on or before the 15th day of the month preceding Coverage Period in which services may be rendered. A grace period of 30 days will be granted for payment of each Cost for Services due after the first Cost for Services, unless the PLAN does not intend to renew the

contract beyond the period for which Cost for Services has been accepted and notice of the intention not to renew is delivered to the contract holder at least 45 days before the Cost for Services is due. During the grace period the contract shall continue in force.

Any additional provisions related to the grace period shall be expressly stated in this group dental benefit contract, subject to the following limitations:

1. Unless the PLAN receives a notice of the GROUP's intention to terminate the policy before the end of the grace period, the PLAN may collect Cost for Services for the 30-day grace period;

2. If the PLAN receives a notice of intention to terminate the GROUP contract during the grace period, the PLAN may collect Cost for Services for the period beginning on the first day of the grace period until the date on which notice is received or the date of termination stated in the notice, whichever is later; and

3. If Cost for Services for the 30-day grace period is paid after the grace period ends, the PLAN may charge interest for the Cost for Services for the GROUP contract, but:

    a. Interest may not begin to accrue during the 30-day grace period; and

    b. The interest rate charged may not exceed an effective rate of 6 percent per year.

B. Cost for Services are to be paid by the Group to the PLAN Administrative Office each month. The Group receives the Cost for Services from their employees by means of payroll deductions. No coverage under this Contract shall commence until the total Cost for Services for the Group for one (1) month is received by the PLAN Administrative Office.

C. Covered Employee Copayments (as listed in the enclosed Schedule of Benefits and Copayments) are payable to the Participating DENTIST at the time service is rendered.

D. A Covered Employee shall agree to remain in the PLAN for a minimum of twelve (12) months. In the event that a Covered Employee voluntarily terminates membership in the PLAN prior to twelve months from the beginning of the first Coverage Period, the Covered Employee may be required to pay the Dentist's charges, less the Cost for Services paid to the PLAN and payments made directly by the Covered Employee to the DENTIST ("Covered Employee Copayments").

5. DUTIES PERFORMED BY GROUP

Group distributes PLAN brochures to all Covered Employees. Upon obtaining applications from employees, Group will initiate payroll deductions to collect monthly Cost for Services. Group will forward application forms and total Cost for Services Payments received from employees to the PLAN Administrative Office by the 15th of each month. The PLAN will deliver to each Covered Employee upon Effective Date of coverage a Membership Identification Card, Schedule of Benefits and Copayments, and a Group Certificate of Coverage that explains the essential features of the plan.

6. BENEFITS AND COVERAGE

A. All dental procedures listed under the attached Schedule of Benefits and Copayments will be provided, if, in the opinion of the Participating DENTIST, they are necessary for the patient's dental health.

B. COORDINATION OF BENEFITS (COB). The PLAN COB policy is based on the "ADA Guidelines on Coordination of Benefits" resolved by the American Dental Association.

1. For the purposes of this COB section, the following term is defined.

   Dental Plan means any dental insurance policy, including those of nonprofit health service plans, and those of commercial group, blanket and individual policies, any subscriber contracts issued by Health Maintenance Organizations (HMOs), and any other established programs under which the insured may make a claim. The term Dental Plan includes coverage under a governmental plan, or coverage required to be provided by law. This does not include a State plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

2. When a patient has coverage under two or more Dental Plans the following rules should apply:

   a. The coverage from those Dental Plans should be coordinated so that the patient receives the maximum allowable benefit from each Dental Plan.

   b. The aggregate benefit should be more than that offered by any of the Dental Plans individually, but not such that the patient receives more than the total charges for the dental services received.

3. In determining order of payment for care, the following rules should apply to Dental Plans:

   a. The Dental Plan covering the patient other than as a dependent is the primary Dental Plan.

   b. When both Dental Plans cover the patient as a dependent child, the Dental Plan of the parent whose birthday occurs first in a calendar year should be considered as primary.

   c. When a determination cannot be made in accordance with the above, the Dental Plan that has covered the patient for the longer time should be considered as primary.

   d. When one of the plans is a medical plan and the other is a Dental Plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as primary.

4. In coordinating care with a Dental Plan which contractually reduces the fees for services which participating dentists accept as payment in full, the following rules should apply:

   a. When the reduced fee Dental Plan is primary and treatment is provided by a participating dentist, the reduced fee is that dentist's full fee unless the dentist has contractually arranged that the reduced-fee Dental Plan should provide its allowed amount for participating dentists and the secondary Dental Plan should pay the lesser of: its allowed benefit for the service or the difference between the primary Dental Plan care and the dentist's full fee. The secondary Dental Plan should pay the lesser of: its allowed benefit or the difference between the primary Dental Plan's benefit and the reduced fee.

   b. When the reduced fee Dental Plan is primary and treatment is provided by a nonparticipating dentist, the reduced fee Dental Plan should provide its allowed amount for nonparticipating dentists and the secondary Dental Plan should pay the

lesser of: its allowed benefit for the service or the difference between the primary Dental Plan care and the dentist's full fee.

c. When a full fee Dental Plan is primary and a reduced fee Dental Plan is secondary, the full fee Dental Plan should provide its allowed amount for the service and the secondary Dental Plan should pay the lesser of: its allowed benefit for the service or the difference between the primary Dental Plan care and the dentist's full fee.

5. In coordinating care between an indemnity Dental Plan and a capitation Dental Plan, the following rules should apply:

a. When the capitation Dental Plan is primary, the capitation payments to the treating dentist remain the capitation Dental Plan's usual care. The indemnity Dental Plan should pay benefits for the patient's surcharges or copayments up to the indemnity Dental Plan's allowable benefit.

b. When the indemnity Dental Plan is primary, and treatment is received from a capitation-participating dentist, the indemnity Dental Plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation Dental Plan's allowable amount.

c. When the indemnity Dental Plan is primary, and treatment is received from a non-capitation participating dentist, the indemnity Dental Plan should pay its allowable benefit. The capitation Dental Plan will pay care, in keeping with the capitation Dental Plan's allowed amount for treatment by nonparticipating dentists.

d. No Dental Plan should contractually direct a dentist to charge a secondary carrier for more than the amount which would be charged to the patient absent secondary coverage.

C. The fees charged will be the fees listed under "Covered Employee Copayments" for each procedure completed. Services listed as "NO CHARGE" in the Schedule of Benefits and Copayments will be performed by the "Personal Participating DENTIST" at no cost to the Covered Employee or Dependent. Any charges for laboratory services or other specialized dental services which are not set forth in the Schedule of Benefits and Copayments shall not exceed the Dentist's charges for such services, and the Covered Employee or Dependent shall be informed of such charges prior to treatment by the "Personal Participating DENTIST."

D. ALTERNATE TREATMENT. Frequently, several methods exist to treat a dental condition. The PLAN will authorize treatment based upon the allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of dental treatment. The PLAN's decision does not commit the Covered Employee to the less expensive procedure. However, if the Covered Employee and the dentist choose the more expensive procedure, the Covered Employee is responsible for the additional charges beyond those authorized or allowed by the PLAN.

E. Only the Personal Participating DENTIST shall have the right to examine and to determine the professional services to be performed pursuant to the PLAN, except in the instance of out-of-area dental emergency care as specified under Section 14 or in the instance of referral to an Approved Specialist as defined in this Contract.

F. If a conflict arises regarding the quality and extent of work, the case in question will be submitted to the PLAN Dental Director for resolution. See Section 22 for procedure for Complaints and Grievances.

G. A ninety (90) day extension of benefits is applicable to all dental services begun while coverage was in effect, i.e., if a dental service was begun while coverage was in effect for the Covered Employee or Dependent, PLAN agrees that the Personal Participating DENTIST will complete such dental services within 90 days with no change in or addition to the Covered Employee Copayments. Orthodontic coverage shall be provided, in accordance with the policy in effect at the time the Covered Employee and/or Dependent('s) coverage terminates, for sixty (60) days after the date the coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or until the later of sixty (60) days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

H. Coverage of Covered Employee or Dependent(s) will not be terminated or discontinued solely because of clerical error on the part of the Group or PLAN.

7. REFERRALS

Any covered specialty services received by Covered Employee or Dependent must be approved in writing by Covered Employee or Dependent's "Personal Participating DENTIST." Should the "Personal Participating DENTIST" wish to refer Covered Employee or Dependent to a non-approved specialist, the referral must be approved in writing by the PLAN to be eligible for coverage.

A standing specialist referral will be made if the "Personal Participating DENTIST," in consultation with the specialist, determines that the patient needs continuing care from the specialist for conditions or diseases that are life threatening, degenerative, chronic, disabling, and require specialized care. The specialist shall have expertise in treating the life threatening, degenerative, chronic, or disabling disease or condition and be part of the PLAN's provider panel. The standing referral shall be made in accordance with a written treatment plan for a covered service developed by the "Personal Participating DENTIST," the specialist, and the Covered Employee or Dependent. The treatment plan may limit the number of visits to the specialist, limit the period of time in which visits to the specialist are authorized, and require the specialist to communicate regularly with the "Personal Participating DENTIST" regarding the treatment and health status of the Covered Employee or Dependent.

A Covered Employee or Dependent may request a referral to a specialist who is not part of the PLAN's provider panel if the Covered Employee or Dependent is diagnosed with a condition or disease that requires specialist medical care and the PLAN does not have in its provider panel a specialist with the professional training and expertise to treat the condition or disease, or if the PLAN cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay and/or travel. For purposes of calculating any deductible, copayment amount, or coinsurance payable by the Covered Employee or Dependent, the PLAN shall treat services received as if the service was provided by a provider on the PLAN's provider panel. A decision by the PLAN not to provide access to or coverage of treatment by a specialist in accordance with this section constitutes an Adverse Decision if the decision is based on a finding that the proposed service is not medically necessary, appropriate, or efficient.

If a PLAN DENTIST refers the Covered Employee or Dependent to a specialist who is not a PLAN DENTIST, the PLAN shall be responsible for payment of the specialist's charges to the extent the charges exceed the copayment specified in the enclosed Schedule of Benefits.

CLAIMS PROCEDURES FOR "OUT-OF-AREA EMERGENCY CARE AND REFERRALS TO NON-PARTICIPATING SPECIALISTS." In order to institute payment procedures in the case of out-of-area emergency care and/or an approved referral to a specialist who is not a "Participating DENTIST," it shall be necessary for the Covered Employee and/or Dependent(s) making such claim to submit a fully completed claim form to PLAN. PLAN will provide claim forms to Covered Employee and/or Dependents upon request and within 15 days. In the event that the out-of-area provider and/or non-Participating DENTIST has accepted assignment of the Covered Employee

and/or Dependents rights to payment hereunder, the claim form shall so indicate. The PLAN shall make the payment of its portion of the charge directly to the provider or providers pursuant to such authorization. If the Covered Employee and/or Dependents has made payment of the PLAN benefit to an out-of-area provider and/or non-Participating DENTIST, the claim form shall be accompanied by proof of such payment in a manner satisfactory to PLAN and a designation by the Covered Employee and/or Dependent or the person to whom reimbursement should be made. PLAN shall then reimburse the Covered Employee and/or Dependent or his/her designee directly. If the PLAN does not provide claim forms within 15 days after notice of claim is received, the Covered Employee and/or Dependent are considered to have complied with the requirements of the contract as to proof of loss if the Covered Employee and/or Dependent submit, within the time fixed in the contract for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

All claims must be submitted to the PLAN on American Dental Association approved claim forms. You may contact the PLAN to obtain such forms. The claim form must be submitted to the PLAN within twelve (12) months of the date of service. Failure to provide a written claim within twelve (12) months will invalidate and/or reduce the obligation under this contract, unless the Covered Employee can show that it was not possible to send a written claim. The Covered Employee shall then furnish a written claim as soon as reasonably possible. Benefits payable for any loss will be paid not more than thirty (30) days after receipt of written proof of loss.

8. PLAN LIMITATIONS

The following exclusions and limitations shall apply:

PLAN LIMITATIONS

- Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws;
- Services which are provided without cost to the Covered Employee and/or Dependent(s) by any municipality, county or other political subdivision (with the exception of Medicaid);
- Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Employee and/or Dependent(s) health;
- Payment of any claim or bill will not be made for prohibited referrals;
- Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient's dental health;
- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
- Dispensing of drugs, except those used as a local anesthetic;
- Hospitalization for any dental procedure;
- Loss or theft of bridgework or dentures previously supplied under the PLAN;
- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
- Any implantation;
- General anesthesia;
- Services that cannot be performed because of the general health of the patient;
- Teeth Cleaning (Prophylaxis) at intervals of less than six (6) months;
- Unlisted procedures will be provided at the dentist's charges;
- Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
- Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Employee's and/or Dependent(s) "Personal Participating DENTIST;"
- All services listed on the Schedule of Benefits and Member Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general

DENTIST will refer the Covered Employee and/or Dependent(s) to an approved Specialist or recommend that the Covered Employee and/or Dependent(s) contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care, and a referral to a non-participating general dentist or specialist;

- Services which cannot be performed in the dental office of the "Personal Participating DENTIST" or "Approved Specialist" due to the special needs or health related conditions of the Covered Employee and/or Dependent(s).

OUT-OF-AREA EMERGENCY CARE: *Covered Employees and/or Dependent(s) are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their "Personal Participating DENTIST." Limited to $50 per Covered Employee and/or Dependent(s) per emergency.*

ALL PRICES ARE EXCLUSIVE OF GOLD

9. RENEWAL

The PLAN will provide GROUP with a written notification of any changes to Schedule of Benefits and Copayments and/or Cost for Services (monthly premium) at least sixty (60) days prior to the effective date of Group Renewal. If the GROUP does not reject the proposed renewal changes, in writing, at least thirty (30) days prior to the renewal date, the Group Dental Services Contract will be amended to include the changes to Schedule of Benefits and Copayments and/or Cost for Services.

10. DENTAL RECORDS

The dental records of all Covered Employees and Dependents concerning services performed hereunder shall remain the property of the "Personal Participating DENTIST." The Covered Employee and/or Dependent(s) may be subject to a charge for the duplication of dental records and radiographs in accordance with Maryland law.

11. CHANGE IN COST FOR SERVICES OR COVERED EMPLOYEE COPAYMENTS

The PLAN guarantees that the Cost for Services set forth herein shall not be increased during each individual year of the Term. The Reduced Rate charges set forth in the Schedule of Benefits and Copayments are guaranteed during each individual year of the Term, with the exception of gold crown and bridgework (gold will be charged to the Covered Employee at market prices). Upon completion of each individual year of Term, the PLAN reserves the right to change the Cost for Services or Covered Employees Copayments. Notice of any change will be given sixty (60) days prior to the Annual Termination Date.

12. CONTINUATION OF SERVICES AFTER TERMINATION OF UNDERLYING EMPLOYMENT

A. Payroll deduction for PLAN coverage for Covered Employees and their Dependents will terminate when Covered Employee ceases to be an eligible employee of the Group. In order to continue coverage, the Covered Employee shall pay the Cost for Services at the Group rate on an annual basis only, thereby maintaining the same coverage previously paid through payroll deductions and under the terms of this Contract. The Covered Employee must forward the annual payment to the PLAN Administrative Office within thirty (30) days after ceasing to be an eligible employee of the Group.

B. The Participating DENTIST shall notify the Covered Employees or Dependent of the termination of this Contract if the Covered Employee or Dependent visits the DENTIST's office when the DENTIST is aware that the Contract has terminated, and under such circumstances, the Participating DENTIST shall inform the Covered Employee or Dependent of the charge for any scheduled dental services before performing any such dental service.

13. CHANGING DENTISTS

Covered Employees may transfer coverage for themselves and Dependents to another Participating DENTIST. Transfers may be made with notification to the PLAN Administrative Office which includes the Covered Employee's Name and Policy Number, new "Personal Participating DENTIST" selected, the reason for changing and the date of the last appointment with current Participating DENTIST. Transfers will be effective on the first day of the following month.

14. OUT-OF-AREA EMERGENCY CARE

Covered Employees and Dependents, when temporarily more than fifty (50) miles from their "Personal Participating DENTIST," may have emergency care rendered by any licensed DENTIST. Emergency care is defined as "emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness." PLAN pays for emergency out-of-area care up to Fifty Dollars ($50) per person per emergency. PLAN will reimburse Covered Employee upon presentation of bona fide documentation of emergency care expenses. Written notice to PLAN of claim is not required before twenty (20) days after the occurrence or commencement of the loss covered by the policy. The PLAN may not invalidate or reduce a claim if it is shown that it was not reasonably possible to give notice within 20 days, and notice was given as soon as was reasonably possible.

15. BROKEN APPOINTMENTS

The Covered Employee and Dependents may cancel or break an appointment without penalty if the dental office is given advance notice of twenty-four (24) hours or more. If sufficient advance notice is not given, the Covered Employee or Dependent is responsible for the payment of a fee as specified in the Schedule of Benefits and Copayments.

16. MAJOR DISASTERS AND OTHER CATASTROPHES

In the event of major disaster or epidemic, Participating DENTISTS shall render dental services as provided in this Certificate insofar as is practical, according to their best judgment, within the limitations of such facilities and personnel as are then available, but the PLAN and the Participating DENTISTS shall have no liability or obligation for the delay or failure to provide or arrange for such services if such delay or failure is the result of such disaster or epidemic, except as may be mandated by the Insurance Commissioner of the State of Maryland.

If, during the term of this Contract, none of the Participating DENTISTS or Approved Specialists can render necessary care and treatment to the Covered Employee or Dependents due to circumstances not reasonably within the control of the PLAN, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes or the disability of a significant number of the Participating DENTISTS, the Covered Employee may seek treatment from an independent licensed DENTIST of his own choosing. The PLAN will reimburse the Covered Employee for such services; provided, however, that the PLAN will reimburse the Covered Employee for services which are listed in the Schedule of Benefits and Copayments as "No Charge," only to the extent that such fees are approved by the PLAN, and the PLAN will further reimburse the Covered Employee for those services listed in the Schedule of Benefits and Copayments for which there is a monetary surcharge, to the extent that the dentist's charges for such services exceed the reduced charge for such services as set forth in the Schedule of Benefits and Copayments. The Covered Employee shall be required to give written proof of loss. The PLAN agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner with respect to any determination of the impossibility of providing services by PLAN DENTISTS.

17. REMEDIES IN CASE OF DEFAULT

In the event that a Personal Participating DENTIST is unable to provide care and treatment to a Covered Employee or Dependent during the Coverage Period, the Covered Employee shall be obligated to select another Personal Participating DENTIST from the list of Participating DENTISTS, and the Covered Employee shall notify the PLAN of such change.

18. PROFESSIONAL LIABILITY INSURANCE

Participating DENTISTS and Approved Specialists shall at all times carry professional liability insurance with annual coverage of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate, and shall provide proof of such coverage to the PLAN upon demand.

19. REPRESENTATIONS AND NOT WARRANTIES

All statements made by Covered Employees or the Group shall be deemed to be representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written instrument signed by the Group or the Covered Employee, a copy of which has been furnished to the Group or the Covered Employee.

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

20. ENTIRE CONTRACT; CHANGES

A. This Contract, including the Group Application, Group Certificate of Coverage, and endorsements, if any, constitutes the entire contract between the parties. No change in this Contract shall be valid until approved by an executive officer of the PLAN and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Contract or to waive any of its provisions.

B. This Contract shall be construed according to the laws of the State of Maryland.

C. Any provision of this Contract which, on its Effective Date, is in conflict with the Laws of the State of Maryland is hereby amended to conform to the minimum requirements of such laws.

D. Upon any anniversary of the Effective Date, the Contract shall be automatically revised to conform to minimum statutory requirements of applicable statutes enacted subsequent to the prior anniversary.

21. HOW TO RECEIVE BENEFITS

In order to make an appointment, the Covered Employee must telephone the office of the "Personal Participating DENTIST" selected. The Covered Employee must pay the fees listed on the Schedule of Benefits and Copayments directly to the "Personal Participating DENTIST" who renders treatment.

22. COMPLAINTS AND GRIEVANCES

Definitions:

A. "Adverse Decision" means a utilization review determination made by appropriate review agent, the PLAN, or a Health Care Provider acting on behalf of the PLAN, that a proposed or delivered health care service:

1. is or was not dentally necessary, appropriate, or efficient.

2. may result in non-coverage of health care service.

"Adverse Decision" does not include a decision concerning a subscriber's status as a Covered Employee and/or Dependent(s).

B. "Complaint" means a protest filed with the Commissioner involving an Adverse Decision or Grievance Decision concerning the Covered Employee and/or Dependent.

C. "Filing Date" means the earlier of:

1. five days after the date of mailing, or

2. the date of receipt.

D. "Grievance" means a protest filed by a Covered Employee and/or Dependent or a Health Care Provider on behalf of a patient with a private review agent's internal grievance process regarding an Adverse Decision concerning a patient. "Grievance" does not include a verbal request for reconsideration of a utilization review determination.

E. "Grievance Decision" means a final determination by the PLAN that arises from a Grievance filed with the PLAN under its internal grievance process regarding an Adverse Decision concerning a Covered Employee and/or Dependent(s).

F. "Health Care Provider" means an individual who is licensed under the health occupation articles to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Covered Employee and/or Dependent(s).

Emergency Grievance:

The PLAN has an expedited procedure for use in cases of emergency for purposes of rendering a Grievance Decision within twenty-four (24) hours after filing the Grievance. The Covered Employee and/or Dependent(s) and/or Health Care Provider acting on behalf of the Covered Employee and/or Dependent(s) should request a grievance form. The PLAN will fax this form as directed by the Covered Employee and/or Dependent(s) and/or Health Care Provider acting on behalf of the Covered Employee and/or Dependent(s). The Covered Employee and/or Dependent(s) and/or Health Care Provider should complete the grievance form and fax it back to the PLAN at the fax number (410) 847-9062. In the event that a determination needs to be made regarding the existence of an emergency case, our Dental Director will make the determination. An expedited review of an Adverse Decision in accordance with this regulation is required if the:

1. Adverse Decision is rendered for health care services that are proposed but have not been delivered; and

2. services are necessary to treat a condition or illness that without immediate attention would:

a. seriously jeopardize the life or health of the Covered Employee and/or Dependent(s) or the Covered Employee and/or Dependent(s) ability to regain maximum function, or

b. cause the Covered Employee and/or Dependent(s) to be in danger to self or others.

If the PLAN does not have sufficient information to complete its internal grievance process the PLAN will notify and assist the Covered Employee and/or Dependent(s) or Covered Employee and/or Dependent(s) representative in gathering information from the appropriate sources without delay. The Covered Employee and/or Dependent(s) or provider acting on the Covered Employee and/or Dependent(s) behalf may file a Complaint with the Insurance Commissioner if the Covered Employee and/or Dependent(s) or provider acting on the Covered Employee and/or Dependent(s) behalf has not received a Grievance Decision within twenty-four (24) hours after the emergency Grievance was filed. For an emergency case, within one (1) day after a decision has been orally communicated to the Covered Employee and/or Dependent(s) or Health Care Provider, the PLAN shall send notice in writing of any Grievance Decision to the Covered Employee and/or Dependent(s) and the Health Care Provider if acting on behalf of the Covered Employee and/or Dependent(s).

The written notice will state in detail in clear, understandable language the specific factual basis for the PLAN's decision; reference the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not use only generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary". It will also state the name, business address, and business telephone number of the Dental Director and include the following information:

Dental Director
The Dental Network
10455 Mill Run Circle
Owings Mills, Maryland 21117
410-847-9060

The Covered Employee and/or Dependent(s) or a provider on behalf of the Covered Employee and/or Dependent(s) has a right to file a Complaint with the Commissioner (address listed below), within thirty (30) working days after receipt of the PLAN's Grievance Decision.

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
1-800-492-6116 or 410-468-2000
Fax 410-468-2270

Non-Emergency Procedures:

The PLAN will allow a Grievance to be filed on behalf of a Covered Employee and/or Dependent(s) by a Health Care Provider. The PLAN also provides that a final decision be rendered on a Grievance involving a prospective denial within 30 working days after Grievance Filing Date, except for emergency cases or if the Covered Employee and/or Dependent(s) or Health Care Provider agrees in writing to an extension of no longer than thirty (30) working days. The Grievance must be filed within ninety (90) days of the date of notification of an Adverse Decision. The Grievance may be filed orally or in writing and must contain relevant documentation, which contains sufficient detail to identify the nature of the problem. The PLAN will notify the Covered Employee and/or Dependent(s) or Health Care Provider within five (5) working days after the Filing Date, that it does not have sufficient information to complete the grievance process and that it cannot proceed with review unless additional information is provided and that the PLAN will assist the Covered Employee and/or

Dependent(s) or provider in gathering the necessary information without further delay. The PLAN will render a final decision within 45 working days after the date on which the Grievance is filed when the Grievance involves a retrospective denial; and allow a Covered Employee and/or Dependent or a Health Care Provider on behalf of a Covered Employee and/or Dependent to file a Grievance within 180 days after the Covered Employee and/or Dependent receives an Adverse Decision.

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTHCARE SERVICES. You may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
410-528-1840 or 1-877-261-8807 (toll-free)
Fax 410-576-6571
www.heau@oag.state.md.us

With the written consent of a Covered Employee and/or Dependent(s) or Health Care Provider the period of time for making a final decision may be extended for a period of no longer than thirty (30) working days.

In the case of a non-emergency Grievance, oral communication will be made within 24 hours after decision has been made. The PLAN will document in writing any Grievance Decision that has been orally communicated to the Covered Employee and/or Dependent(s) or Health Care Provider within five (5) working days after the decision has been made. A notice will be sent to the Covered Employee and/or Dependent(s) and any Health Care Provider who filed a Grievance on behalf of the Covered Employee and/or Dependent(s). A Complaint may be filed if the Covered Employee and/or Dependent(s) or Health Care Provider filing a Grievance on behalf of the Covered Employee and/or Dependent(s) has not received a Grievance Decision on or before the 30th working day after the Filing Date of the Grievance concerning services not yet rendered, or the forty-fifth (45) working day for a retrospective denial, unless the Covered Employee and/or Dependent or Health Care Provider filing a Grievance on behalf of a Covered Employee and/or Dependent agrees in writing to an extension for a period of no longer than 30 working days.

A Covered Employee and/or Dependent or a Health Care Provider filing a Complaint on behalf of a Covered Employee and/or Dependent may file a Complaint with the Commissioner without first filing a Grievance with the PLAN and receiving a final decision on the Grievance if the Covered Employee and/or Dependent or a Health Care Provider provides sufficient information and supporting documentation in the Complaint that demonstrates a compelling reason to do so.

This notice will state in detail in clear, understandable language the specific factual basis for the PLAN's decision; reference the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not use only generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary." It will also state the name, business address, and business telephone number of the Dental Director and include the following information:

The Covered Employee and/or Dependent(s) or a provider on behalf of the Covered Employee and/or Dependent(s) has a right to file a Complaint with the Commissioner (address listed below), within thirty (30) working days after receipt of the PLAN's Grievance Decision.

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
1-800-492-6116 or 410-468-2000
Fax 410-468-2270

23. COVERAGE DECISION COMPLAINT PROCESS

A. Definitions:

"Appeal" means a protest filed by a Covered Employee and/or Dependent or Health Care Provider with the PLAN under its internal appeal process regarding a coverage decision concerning a Covered Employee and/or Dependent.

"Appeal Decision" means a final determination by the PLAN that arises from an appeal filed with the PLAN under its appeal process regarding a coverage decision concerning a Covered Employee and/or Dependent.

"Coverage Decision" means an initial determination by the PLAN that results in non-coverage of a health care service.

"Urgent Medical Condition" means a condition that satisfies either of the following:

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the PLAN, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine to result in:

    a. Placing the Covered Employee and/or Dependent's life or health in serious jeopardy;

    b. The inability of the Covered Employee and/or Dependent to regain maximum function;

    c. Serious impairment to bodily function;

    d. Serious dysfunction of any bodily organ or part; or

    e. The Covered Employee and/or Dependent remaining seriously mentally ill with symptoms that cause the Covered Employee and/or Dependent to be danger to self or others; or

2. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours in the option of a Health Care Provider with knowledge of the Covered Employee and/or Dependent's medical condition, would subject the Covered Employee and/or Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

B. The PLAN shall render a final decision in writing to a Covered Employee and/or Dependent, and a Health Care Provider acting on behalf of the Covered Employee and/or Dependent, within 60 working days after the date on which the appeal is filed. The PLAN's internal appeal process

must be *exhausted* prior to filing a Complaint with the Commissioner. A Covered Employee or a Health Care Provider filing a Complaint on behalf of a Covered Employee and/or Dependent may file a Complaint with the Maryland Insurance Commissioner without filing an appeal with the PLAN only if the coverage decision involves an urgent medical condition for which care has not been rendered.

Within 30 calendar days after a coverage decision has been made, the PLAN shall send a written notice of the coverage decision to the Covered Employee and/or Dependent and the treating Health Care Provider which states in clear, understandable language, the specific factual basis for the PLAN's decision and include the following information:

1. The Covered Employee and/or Dependent, or a Health Care Provider acting on behalf of the Covered Employee and/or Dependent, has a right to file an appeal with the PLAN.

2. That the Covered Employee and/or Dependent, or a Health Care Provider acting on behalf of the Covered Employee and/or Dependent, may file a Complaint with the Maryland Insurance Commissioner without first filing an appeal, if the coverage decision involves an urgent medical condition for which care has not been rendered;

3. The Maryland Insurance Commissioner's address, telephone number, and facsimile number:

Maryland Insurance Administration
Life and Health Complaint Department
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
1-800-492-6116 or 410-468-2244
Fax 410-468-2260

4. The Health Advocacy Unit is available to assist the Covered Employee and/or Dependent in both mediating and filing an appeal under the PLAN's internal appeal process and can be reached at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
410-528-1840 or 1-877-261-8807 (toll-free)
Fax 410-576-6571
www.heau@oag.state.md.us

Within 30 calendar days after the appeal decision has been made, the PLAN shall send to the Covered Employee and/or Dependent, and the Health Care Provider acting on behalf of the Covered Employee and/or Dependent, a written notice of the appeal decision which states in clear, understandable language the specific factual basis for the PLAN's decision and includes the statement that the Covered Employee and/or Dependent, or a Health Care Provider acting on behalf of the Covered Employee and/or Dependent, has a right to file a Complaint with the Maryland Insurance Commission within 60 working days after receipt of the PLAN's appeal decision at:

Maryland Insurance Administration
Life and Health Complaint Department
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
1-800-492-6116 or 410-468-2244
Fax 410-468-2260

The Maryland Insurance Commissioner shall issue in writing a final decision on all Complaints filed and provide notice in writing to all parties of the opportunity and time period for requesting a hearing to be held to contest a final decision of the Maryland Insurance Commissioner.

Any Complaints about the PLAN other than coverage decisions or Grievances may be forwarded to:

Maryland Insurance Administration
Life and Health Complaint Department
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
1-800-492-6116 or 410-468-2244
Fax 410-468-2260

24. PRIVACY NOTIFICATION

When the Covered Employee and/or Dependent(s) apply for any type of insurance, they disclose information about themselves and/or members of their family. The collection, use, and disclosure of this information is regulated by law. Safeguarding the Covered Employee and/or Dependent(s) personal and/or financial information is something the PLAN takes very seriously.

The PLAN may collect nonpublic, personal, financial and medical information about the Covered Employee and/or Dependent(s) from various sources, including:

- Information provided on application or other forms, such as name, address, social security number, age, and gender.
- Information pertaining to Covered Employee and/or Dependent(s) relationship with the PLAN, its affiliates, or others such as policy coverage, premiums, and claims payment history.
- Information (as described in preceding paragraphs) that the PLAN obtains from any of our affiliates.
- Information the PLAN receives from other sources such as Covered Employee and/or Dependent(s) employer, provider, and other third parties.

At no time does the PLAN disclose the Covered Employee and/or Dependent(s) health and/or financial information to anyone outside of the PLAN unless the PLAN has proper authorization from the Covered Employee and/or Dependent(s) or the PLAN is permitted or required to do so by law. The PLAN maintains physical, electronic, and procedural safeguards in accordance with federal and state standards that protects the Covered Employee and/or Dependent(s) information.

In addition, the PLAN limits access to the Covered Employee and/or Dependent(s) personal information to those the PLAN employees, brokers, group health plan administrators, providers, and agents who need to know this information to conduct the PLAN business or to provide products or services to the Covered Employee and/or Dependent(s).

In order to protect the Covered Employee and/or Dependent(s) privacy, affiliated and nonaffiliated entities are subject to strict confidentiality. When the PLAN shares information with a nonaffiliated entity it is because it is a critical business partner that assists us in providing services to the Covered Employee and/or Dependent(s). The information the PLAN provides can only be used to provide services the PLAN has asked them to perform for the PLAN or for the Covered Employee and/or Dependent(s) and/or the Covered Employee and/or Dependent(s) group health plan.

If the PLAN collects personally identifiable medical and/or financial information, the PLAN will not share this information either internally or externally for any purpose other than the underwriting or administration of an insurance policy or claim or as otherwise specifically disclosed when the

information is collected from the Covered Employee and/or Dependent(s) with their consent.

The PLAN periodically reviews its policies and reserves the right to change them. If the PLAN changes its privacy policy, the PLAN will continue its commitment to keep the Covered Employee and/or Dependent(s) personal information secure—it is our highest priority. The Covered Employee and/or Dependent(s) can always review the PLAN current policy and procedures online at www.carefirst.com.

For questions, please contact the PLAN by calling the Customer Service telephone number listed on the Covered Employee and/or Dependent(s) Membership Identification Card.

25. LEGAL ACTION

An action at law or in equity may not be brought to recover on this contract before the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this contact and after the expiration of three (3) years after the written proof of loss is required to be furnished.

26. ASSIGNMENT AND DELEGATION

The PLAN may assign this Group Certificate of Coverage for the Covered Employee and/or Dependents and its rights hereunder and delegate its duties hereunder to any entity into which it is merged or which substantially acquires all its assets.

27. BLUE CROSS AND BLUE SHIELD DISCLOSURE

Group, on behalf of itself and its participants hereby expressly acknowledges its understanding this contract constitutes a contract solely between Group and PLAN, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting PLAN to use the Blue Cross and/or Blue Shield Service Mark(s) in the State of Maryland and that PLAN is not contracting as the agent of the Association. Group, on behalf of itself and its participants further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than PLAN and that no person, entity, or organization other than PLAN shall be held accountable or liable to Group for any of PLAN's obligations to Group created under this contract. This paragraph shall not create any additional obligations whatsoever on the part of PLAN other than those obligations created under other provisions of this contract.

IN WITNESS THERETO, the parties have caused this Contract to be executed the day, month, and year first written above.

WITNESS:

_____

GROUP REPRESENTATIVE:

BY: _____

PLAN REPRESENTATIVE:

BY: _____

ENCLOSURES: Schedule of Benefits and Copayments
List of Participating Dentists