LOS ALAMOS

INCORPORATED COUNTY OF LOS ALAMOS
SERVICES AGREEMENT

This **SERVICES AGREEMENT** (this "Agreement") is entered into by and between the **Incorporated County of Los Alamos**, an incorporated county of the State of New Mexico ("County"), and Delta Dental of New Mexico, a New Mexico corporation ("Contractor"), to be effective for all purposes January 1, 2020.

WHEREAS, the County Purchasing Agent determined in writing that the use of competitive sealed bidding was either not practical or not advantageous to County for procurement of the Services and County issued Request for Proposals No. 20-04 (the "RFP") on June 9, 2019, requesting proposals for Dental Insurance Benefits for Los Alamos County Employees, as described in the RFP; and

WHEREAS, Contractor timely responded to the RFP by submitting a response dated July 24, 2019 ("Contractor's Response"); and

WHEREAS, based on the evaluation factors set out in the RFP, Contractor was the successful Offeror for the services listed in the RFP; and

WHEREAS, the County Council approved this Agreement at a public meeting held on October 29, 2019; and

WHEREAS, Contractor will provide the Services, as described below, to County.

NOW, THEREFORE, for and in consideration of the premises and the covenants contained herein, County and Contractor agree as follows:

SECTION A. SERVICES: Contractor shall provide County with Administrative Services for Group Dental Insurance Benefits pursuant to the terms of the Administrative Services Agreement, Group Dental Benefits Handbook and Summary of Benefits. The final Administrative Services Agreement (Attachment 1), Dental Benefits Handbook (Attachment 2), Summary of Benefits (Attachment 3) and the Business Associate Agreement (Attachment 4), shall be attached to and become part of this Agreement for all purposes. Contractor is responsible for providing insurance coverage as identified in Attachments 1 through 4.

SECTION B. TERM: The term of this Agreement shall commence January 1, 2020 and shall continue through December 31, 2023, unless sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to three (3) consecutive one-year periods, or one (1) continuous three-year period, unless sooner terminated, as provided therein, under the same terms and conditions, contingent upon Council appropriating funding.

SECTION C. COMPENSATION:

1. **Amount of Compensation**. County shall pay compensation for performance of the Services in Years 1, 2, 3 and 4 in accordance with the rate schedule set out in Exhibit "A," attached hereto and made a part hereof for all purposes, an amount not to exceed ONE HUNDRED FORTY THOUSAND DOLLARS ($140,000.00), which amount does not include applicable

New Mexico gross receipts taxes ("NMGRT"). Beginning with year five (5) and for any subsequent renewal periods, compensation will be strictly based upon rate negotiations with Contractor, not to exceed 7% of prior year's rates, and Council approval of said negotiations as set forth in Section B above.

2. **Monthly Invoices**. Contractor shall submit itemized *monthly* invoices to County's Benefits Staff showing amount of compensation due, amount of any NMGRT, and total amount payable. Payment of undisputed amounts shall be due and payable thirty (30) days after County's receipt of the invoice.

SECTION D. TAXES: Contractor shall be solely responsible for timely and correctly billing, collecting and remitting all NMGRT levied on the amounts payable under this Agreement.

SECTION E. STATUS OF CONTRACTOR, STAFF, AND PERSONNEL: This Agreement calls for the performance of services by Contractor as an independent contractor. Contractor is not an agent or employee of County and will not be considered an employee of County for any purpose. Contractor, its agents or employees shall make no representation that they are County employees, nor shall they create the appearance of being employees by using a job or position title on a name plate, business cards, or in any other manner, bearing County's name or logo. Neither Contractor nor any employee of Contractor shall be entitled to any benefits or compensation other than the compensation specified herein. Contractor shall have no authority to bind County to any agreement, contract, duty or obligation. Contractor shall make no representations that are intended to, or create the appearance of, binding County to any agreement, contract, duty, or obligation. Contractor shall have full power to continue any outside employment or business, to employ and discharge its employees or associates as it deems appropriate without interference from County; provided, however, that Contractor shall at all times during the term of this Agreement maintain the ability to perform the obligations in a professional, timely and reliable manner.

SECTION F. STANDARD OF PERFORMANCE: Contractor agrees and represents that it has and will maintain the personnel, experience and knowledge necessary to qualify it for the particular duties to be performed under this Agreement. Contractor shall perform the Services described herein in accordance with a standard that meets the industry standard of care for performance of the Services.

SECTION G. DELIVERABLES AND USE OF DOCUMENTS: All deliverables required under this Agreement, including material, products, reports, policies, procedures, software improvements, databases, and any other products and processes, whether in written or electronic form, shall remain the exclusive property of and shall inure to the benefit of County as works for hire; Contractor shall not use, sell, disclose, or obtain any other compensation for such works for hire. In addition, Contractor may not, with regard to all work, work product, deliverables or works for hire required by this Agreement, apply for, in its name or otherwise, any copyright, patent or other property right and acknowledges that any such property right created or developed remains the exclusive right of County. Contractor shall not use deliverables in any manner for any other purpose without the express written consent of County.

SECTION H. EMPLOYEES AND SUB-CONTRACTORS: Contractor shall be solely responsible for payment of wages, salary or benefits to any and all employees or contractors retained by Contractor in the performance of the Services. Contractor agrees to indemnify, defend and hold harmless County for any and all claims that may arise from Contractor's relationship to its employees and subcontractors.

SECTION I. INSURANCE: Contractor shall obtain and maintain insurance of the types and in the amounts set out below throughout the term of this Agreement with an insurer acceptable to County. Contractor shall assure that all subcontractors maintain like insurance. Compliance with the terms and conditions of this Section is a condition precedent to County's obligation to pay compensation for the Services and Contractor shall not provide any Services under this Agreement unless and until Contractor has met the requirements of this Section. County requires Certificates of Insurance or other evidence acceptable to County that Contractor has met its obligation to obtain and maintain insurance and to assure that subcontractors maintain like insurance. Should any of the policies described below be cancelled before the expiration date thereof, notice will be delivered in accordance with the policy provisions. General Liability Insurance and Automobile Liability Insurance shall name County as an additional insured.

1. **General Liability Insurance:** ONE MILLION DOLLARS ($1,000,000.00) per occurrence; TWO MILLION DOLLARS ($2,000,000.00) annual aggregate.
2. **Workers' Compensation:** In an amount as may be required by law. County may immediately terminate this Agreement if Contractor fails to comply with the Worker's Compensation Act and applicable rules when required to do so.
3. **Automobile Liability Insurance for Contractor and its Employees:** ONE MILLION DOLLARS ($1,000,000.00) combined single limit per occurrence; TWO MILLION DOLLARS ($2,000,000.00) annual aggregate on any owned, and/or non-owned motor vehicles used in performing Services under this Agreement.
4. **Errors and Omissions/Professional Liability Insurance:** whichever is applicable to the particular profession or service to be provided, with a limit of not less than $1,000,000 each Claim, with a $2,000,000 annual aggregate, without any restrictive "negligent act, negligent error, or negligent omission" clause, and sufficient to protect the Contractor and the County for a three (3) year period from the completion of this contract, against any and all claims which may arise from the Contractor's negligent performance of work described herein.

SECTION J. RECORDS: Contractor shall maintain, throughout the term of this Agreement and for a period of six (6) years thereafter, records that indicate the date, time, and nature of the services rendered. Contractor shall make available, for inspection by County, all records, books of account, memoranda, and other documents pertaining to County at any reasonable time upon request.

SECTION K. APPLICABLE LAW: Contractor shall abide by all applicable federal, state and local laws, regulations, and policies and shall perform the Services in accordance with all applicable laws, regulations, and policies during the term of this Agreement. In any lawsuit or legal dispute arising from the operation of this Agreement, Contractor agrees that the laws of the State of New Mexico shall govern. Venue shall be in the First Judicial District Court of New Mexico in Los Alamos County, New Mexico.

SECTION L. NON-DISCRIMINATION: During the term of this Agreement, Contractor shall not discriminate against any employee or applicant for an employment position to be used in the performance of the obligations of Contractor under this Agreement, with regard to race, color, religion, sex, age, ethnicity, national origin, sexual orientation or gender identity, disability or veteran status.

SECTION M. INDEMNITY: Contractor shall indemnify, hold harmless and defend County, its Council members, employees, agents and representatives, from and against all liabilities, damages, claims, demands, actions (legal or equitable), and costs and expenses, including without limitation attorneys' fees, of any kind or nature, arising from Contractor's performance

hereunder or breach hereof and the performance of Contractor's employees, agents, representatives and subcontractors.

SECTION N. FORCE MAJEURE: Neither County nor Contractor shall be liable for any delay in the performance of this Agreement, nor for any other breach, nor for any loss or damage arising from uncontrollable forces such as fire, theft, storm, war, or any other force majeure that could not have been reasonably avoided by exercise of due diligence.

SECTION O. NON-ASSIGNMENT: Contractor may not assign this Agreement or any privileges or obligations herein without the prior written consent of County.

SECTION P. LICENSES: Contractor shall maintain all required licenses including, without limitation, all necessary professional and business licenses, throughout the term of this Agreement. Contractor shall require and shall assure that all of Contractor's employees and subcontractors maintain all required licenses including, without limitation, all necessary professional and business licenses.

SECTION Q. PROHIBITED INTERESTS: Contractor agrees that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contractor further agrees that it will not employ any person having such an interest to perform services under this Agreement. No County Council member or other elected official of County, or manager or employee of County shall solicit, demand, accept or agree to accept a gratuity or offer of employment contrary to Section 31-282 of the Los Alamos County Code.

SECTION R. TERMINATION:

1. **Generally**. County may terminate this Agreement with or without cause upon ten (10) days prior written notice to Contractor. Upon such termination, Contractor shall be paid for Services actually completed to the satisfaction of County at the rate set out in Section C. Contractor shall render a final report of the Services performed to the date of termination and shall turn over to County originals of all materials prepared pursuant to this Agreement.
2. **Funding**. This Agreement shall terminate without further action by County on the first day of any County fiscal year for which funds to pay compensation hereunder are not appropriated by County Council. County shall make reasonable efforts to give Contractor at least ninety (90) days advance notice that funds have not been and are not expected to be appropriated for that purpose.

SECTION S. NOTICE: Any notices required under this Agreement shall be made in writing, postage prepaid to the following addresses, and shall be deemed given upon hand delivery, verified delivery by telecopy (followed by copy sent by United States Mail), or three (3) days after deposit in the United States Mail:

County:
Benefits and Pension Manager
Incorporated County of Los Alamos
1000 Central Avenue, Suite 230
Los Alamos, New Mexico 87544

Contractor:
Rich Bolstad
2500 Louisiana Blvd., Suite 600
Albuquerque, NM 87110

SECTION T. INVALIDITY OF PRIOR AGREEMENTS: This Agreement supersedes all prior contracts or agreements, either oral or written, that may exist between the parties with reference to the services described herein and expresses the entire agreement and understanding between the parties with reference to said services. It cannot be modified or changed by any oral promise

made by any person, officer, or employee, nor shall any written modification of it be binding on County until approved in writing by both County and Contractor.

SECTION U. CAMPAIGN CONTRIBUTION DISCLOSURE FORM: A Campaign Contribution Disclosure Form was submitted as part of the Contractor's Response and is incorporated herein by reference for all purposes. This Section acknowledges compliance with Chapter 81 of the Laws of 2006 of the State of New Mexico.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date(s) set forth opposite the signatures of their authorized representatives to be effective for all purposes on the date first written above.

ATTEST

_____
NAOMI D. MAESTAS
COUNTY CLERK

INCORPORATED COUNTY OF LOS ALAMOS

BY: _____
HARRY BURGESS **DATE**
COUNTY MANAGER

Approved as to form:

_____
J. ALVIN LEAPHART
COUNTY ATTORNEY

DELTA DENTAL OF NEW MEXICO, A NEW MEXICO CORPORATION

BY: _____
NAME: _____ **DATE**
TITLE: _____

Exhibit “A”
Compensation Rate Schedule
AGR20-04

DENTAL SELF FUNDED ASO FEES:	YEARS 1 and 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
MONTHLY ASO FEE: PEPM	**$4.63**	**$4.63**	**$4.63**	**Not-to-Exceed 7% of prior year**	**Not-to-Exceed 7% of prior year**	**Not-to-Exceed 7% of prior year**

One-time loyalty credit of $10,000, to be applied to first invoices dated 1/1/20 until exhausted

ADMINISTRATIVE SERVICES AGREEMENT

ARTICLE 1. DECLARATIONS

This Agreement is effective the 1st day of January, 2020, by and between County of Los Alamos, hereinafter referred to as the Plan Sponsor and Delta Dental Plan of New Mexico, Inc., a New Mexico non-profit corporation, hereinafter referred to as Delta Dental. The benefits and eligibility provisions being administered under the authority of this contract are limited to those described in this contract and/or its attachments. Delta Dental's liability is limited to the benefits stated herein; subject to all the terms of this Agreement having reference thereto. This Declarations Article supersedes any contrary provision of the subsequent articles of this Agreement.

1.1. Effective Date of Agreement Term:

12:01 A.M. Standard Time, January 1, 2020

1.2. Renewal Date:

January 1, 2024 and January 1 of each subsequent year beginning with year five (5) and through year seven (7)

1.3. Group Number: 8524-0001, 9999

1.4. Fee(s)

Plan Sponsor will remit to Delta Dental the fees shown below or as amended:
A Delta Dental Administrative Services Fee of $4.63 per Primary Plan Participant per month. These fees are based upon a 30-day grace period for the payment of fees as detailed in Section 3.2.
ASO fee is guaranteed for four (4) years through 12/31/2023, with a not to exceed 7% of the prior year's fees for years 5-7.

In addition to the Administrative Service Fee, Delta Dental shall invoice Plan Sponsor for the Cost of Claims for the preceding week every Tuesday. Payment shall be due via Electronic Funds Transfer or automatic withdrawals (ACH) on or before Friday of that week.

1.5 Upon execution of this Contract, Delta Dental will provide a one-time renewal credit of $10,000 to the Group's first month's invoice upon renewal. If this Contract is terminated prior to the Contract end date, or proposals are requested from other benefit administrators for an effective date prior to the Contract end date, then this renewal credit will be reduced as follows: The reduction will be determined by dividing the renewal credit by the number of months of this Contract and multiplying the monthly amount by the number of months from the early termination date to the end date of this Contract or from the effective date of a mid-Contract proposal to the end date of this Contract. This renewal credit reduction amount will be immediately due and payable to Delta Dental.

Authorized Plan Sponsor Representative	Delta Dental Plan of New Mexico, Inc.
Printed Name _____	Printed Name JoLou Trujillo-Ottino
Title _____	Title VP of Sales and Marketing
Signature _____	Signature JoLou J. Ottino
Date _____	Date October 14, 2019

Reviewed by Legal Department
MRS 10-14-19

ARTICLE 2. DEFINITIONS

2.1. Administrative Services Fee(s): the fees from the Plan Sponsor due to Delta Dental for Plan administration.

2.2. Administrative Services Agreement or Contract: this document (Articles 1 through 8), including attachments, and successor Agreements or renewals now or hereafter issued or executed.

2.3. COBRA: Title X of Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272) as amended from time to time.

2.4. Contract Term: the period of time from the effective date shown in Article 1 to a specified cancellation or non-renewal date.

2.5. Covered Services: the unique dental services selected for benefits, and subject to the terms and conditions of this Agreement.

2.6. Delta Dental: Delta Dental of New Mexico or Delta Dental Plan of New Mexico, Inc.

2.7. Dental Benefit Handbook: the benefit booklet that shall be provided by Delta Dental upon request, which is not the complete Summary Plan Description provided to Plan Participants by the Plan Sponsor.

2.8. ERISA: Employee Retirement Income Security Act of 1974, as amended.

2.9. Group: the employer named on the Administrative Services application (implementation instructions).

2.10. HIPAA: the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

2.11. Plan Administrator: the Group.

2.12. Plan Participant: an enrolled employee, enrolled dependent, COBRA-enrolled person, or other person who meets the conditions of eligibility outlined by the Plan Sponsor.

2.13. Plan Sponsor: the employer or employee organization that establishes or maintains the Dental Benefit Plan and with whom Delta Dental has this Agreement to provide administrative services related to the Plan.

2.14. Primary Plan Participant: an eligible employee or other person who meets the conditions of individual coverage eligibility outlined by the Plan Sponsor.

OBLIGATIONS OF PLAN SPONSOR

3.1. Plan Sponsor is solely responsible for funding the payment of benefits and expenses of the Plan.

3.2. Plan Sponsor will remit to Delta Dental the Administrative Services Fee(s) stated in Article 1, Declarations, on or before the 5th of month for the month which they were billed, in accordance with Delta Dental's billing statement. **The Plan Sponsor shall be allowed a grace period of thirty (30) days for Administrative Services Fee(s). Failure to pay within the grace period subjects the Contract to possible cancellation by Delta Dental under Article 6.8.** If the Plan Sponsor submits eligibility records in a HIPAA compliant 834 format, they will be used in the determination of the number of Primary Plan Participants for whom Administration Services Fees are due.

3.3. Plan Sponsor will fund claims by making a weekly electronic payment or automatic withdrawal to Delta Dental on or before the Friday of each week for which they were billed, in accordance with Delta Dental's claim payment detail.

3.4. Unless otherwise negotiated by the Plan Sponsor, twelve months of claims run-out services will be provided.

3.5. If during the term of this Agreement, any new tax is imposed upon Delta Dental by any government agency on the amount of administrative and/or claims fees payable under this Agreement or the number of persons covered, Plan Sponsor agrees to the associated increase in fees. The change will be effective as of the date defined under the applicable tax law.

3.6. Any additional fees or services not specifically referenced herein shall be agreed upon in writing by Plan Sponsor and Delta Dental.

3.7. Plan Sponsor shall furnish to Delta Dental the eligibility provisions, dental Plan design, and dental benefits available to Plan Participants by providing Delta Dental with a copy of the dental benefits section of the Plan Document and Summary Plan Description (SPD), or Plan Sponsor shall verify its use of the Delta Dental handbook and/or the Summary of Dental Plan Benefits provided. The Plan Sponsor will provide Delta Dental with a written notice of any changes to the dental benefits section of the Plan Document or the SPD thirty (30) days prior to the date those changes are to become effective. Plan Sponsor acknowledges that Plan design is subject to Delta Dental management information system capabilities. Non-standard plan designs could be subject to an implementation fee.

3.8. Plan Sponsor will determine all eligibility, and manage enrollment, disenrollment, and COBRA obligations. Plan Participants are subject to the provisions of the Plan.

3.9. Notifications of newly eligible persons or enrollment changes must be submitted to Delta Dental within thirty-one (31) days from the date of the person's eligibility or change of status. The Plan Sponsor's failure to submit notifications within the time limit shall not void eligibility for claims payment under this agreement if it is shown it was not reasonably possible for the Plan Sponsor to submit within the thirty-one (31) day period. Retroactive terminations up to 24 months are accepted to allow Delta Dental eligibility records to match those maintained by the Plan. Claim and ASO fee credits are subject to a three (3) month maximum. Provider agreements restrict the time frame during which retroactive claim adjustments can be made.

3.10. Plan Sponsor shall be named the Plan Fiduciary and Plan Administrator and, as such, comply with all duties and responsibilities of a "plan administrator" and program fiduciary as defined and delineated in ERISA, as applicable.

3.11. Plan Sponsor shall be solely responsible for identifying persons entitled to COBRA continuation benefits. Plan Sponsor is responsible for the provision of all required notices in connection with the availability of such benefits, for billing and collecting any payments or contributions required by Plan Sponsor in connection with such benefits, and for otherwise administering all facets of its continuation program. Delta Dental and Plan Sponsor agree that Delta Dental is not a "Plan Administrator" as that term is used in federal laws governing the provision of continuation benefits. Persons availing themselves of continuation benefits through enrollment in Plan Sponsor's Plan shall be considered and treated by Delta Dental in a manner consistent with treatment of active employees of Plan Sponsor. Delta Dental shall assume no obligation with respect to such persons that is different from or in addition to its obligation to non-COBRA Plan Participants.

3.12. Plan Sponsor agrees that, as the Plan sponsor, it is responsible for complying with the Administrative Simplification Requirements of HIPAA, as amended from time to time, and the regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information, 45 CFR 160, 162 and 164 ("Privacy Rule"). Plan Sponsor is responsible for (i) implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of Plan Sponsor's dental Plan; (ii) ensuring that requirements of section 164.504(f)(2)(iii) are supported by reasonable and appropriate security measures; (iii) ensuring that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and (iv) reporting to Plan Sponsor's dental Plan any security incident of which it becomes aware.

ARTICLE 4. ELECTRONIC ENROLLMENT AND ELIGIBILITY (EEE)

4.1. If at the inception of this Agreement, or at any time subsequent to that, the Plan Sponsor requests to maintain eligibility records through the Delta Dental's Dental on-line tool/web based program, Benefit Manager Toolkit (BMT), or through any other electronic enrollment or eligibility format approved by Delta Dental, the following agreement applies. Delta Dental agrees:

4.1.1. To provide the Plan Sponsor with access to the Delta Dental eligibility records which are needed to manage the enrollment and eligibility maintenance of the dental Plan;

4.1.2. To provide EEE at no additional cost to the Plan Sponsor;

4.1.3. To provide the Plan Sponsor with initial EEE training that may be reasonably required prior to enabling EEE, and to accommodate any Plan Sponsor staff changes by providing access to reasonable subsequent training;

4.1.4. To provide the Plan Sponsor access which allows the capability to assign confidential log in and/or password IDs for each designated individual;

4.1.5. When applicable, to terminate individual website access to the Delta Dental eligibility system by the next business day following receipt of notification by the Plan Sponsor of the termination of any individual's EEE access authorization;

4.1.6. To provide, upon request, the Plan Sponsor with an annual (calendar year) schedule reflecting Delta Dental's billing cut off dates;

4.1.7. To generate and provide the Plan Sponsor with online access to monthly billing based on the enrollment and eligibility information provided by the Plan Sponsor through EEE;

4.1.8. To enable all eligibility verification and claims payment functions for the Plan Sponsor's enrolled members immediately upon the Plan Sponsor's entry/update of eligibility data.

4.2. The Plan Sponsor recognizes that EEE transfers the responsibility for maintenance of dental plan eligibility and enrollment to the Plan Sponsor and that all electronic entries are immediately "live" in the Delta Dental claims processing system. The Plan Sponsor agrees:

4.2.1. To designate the individual(s) who will be authorized by the Plan Sponsor to manage enrollment and eligibility maintenance for the dental plan and to notify Delta Dental by the next business day following the termination of the employment or EEE authorization for said individual(s);

4.2.2. To require that individuals authorized for EEE access will receive training from either Delta Dental or an employee at the Plan Sponsor who has previously received EEE training;

4.2.3. To establish a policy and procedure for the security of EEE login and password IDs provided by Delta Dental;

4.2.4. To follow the eligibility guidelines specified by the Plan Sponsor and approved by Delta Dental;

4.2.5. To enter enrollment and eligibility updates on a timely basis as defined by the Delta Dental billing cut off cycles;

4.2.6. That every reasonable effort will be made to ensure the accuracy of the enrollment and eligibility data transmitted;

4.2.7. To protect and preserve the confidentiality of enrollment and eligibility information provided in the Plan Sponsor's on-site dental plan records, including but not limited to enrollment documentation that could include court orders, divorce or other personal records needed to administer eligibility;

4.2.8. That information, if any, which is of a proprietary nature and required solely for EEE documentation will not be released to any other party without the express written consent of Delta Dental or the individual/guardian to which the documentation refers;

4.3. Delta Dental provides no guarantees as to the future availability of the Plan Sponsor's EEE access and retains the right to cancel, without advance notice, EEE access if enrollment fraud or abuse is determined.

4.4. The Plan Sponsor authorizes Delta Dental to recover from enrollees, on behalf of the Plan, any claims payments based on inaccurate enrollment or eligibility information provided by the Plan Sponsor that would not have been made in the absence of incorrect data entry.

ARTICLE 5. OBLIGATIONS OF DELTA DENTAL

5.1. Delta Dental shall provide administration for enrollees covered under the Plan Sponsor's dental Plan including:

5.1.1. for all claims incurred and paid during the term of this Agreement, determination of benefit payments in accordance with (a) the provisions of the Summary of Dental Plan Benefits and the Dental Benefit Handbook described in Attachment 1 and Attachment 2, respectively, which are

included herein by reference, and (b) specific information regarding Plan Participants' dental history and claims processing history in Delta Dental possession;

5.1.2. provision of an established network of participating dentists who have agreed to Delta Dental Maximum Approved Fees for covered dental services provided to Plan Participants and who agree to charge the Plan Participant only the patient deductible, copayment, non-covered services and tax, as applicable. Delta Dental requires participating dentists to adhere to Delta Dental credentialing and claims processing policies.

5.1.3. issuance of benefit payments to: a) Delta Dental participating providers who perform covered services for Plan Participants, or b) Plan Participant or other designated payees when non-participating providers perform covered dental services, in the form of checks which Delta Dental shall mail directly to payees;

5.1.4. if requested by the Plan Sponsor, Delta Dental will make available a Dental Benefit Handbook to each Primary Plan Participant when initially enrolled as shown in Article 8, Attachment 2. Handbooks requiring customization may be subject to separate fees.

5.1.5. make available an Explanation of Benefits (EOBs) to dentists and Plan Participants;

5.1.6. provision of customer service representatives for Plan Participants and their dentists to address inquiries or complaints, eligibility, Plan interpretation, claims, benefits and other matters relevant to the administration of the Plan. These representatives shall have access to online eligibility and Plan design parameters as well as specific information regarding dental history and claims processing information;

5.1.7. dental, peer review, clinical review and other professional expertise necessary to properly adjudicate claims;

5.2. Delta Dental will select and maintain the bank account to which Plan Sponsor will direct payment of Administrative Fees and claims payments.

5.3. Delta Dental will provide Plan Sponsor a weekly claims payment report and a weekly claims summary report of claims paid on behalf of the Plan. Plan Sponsor will reimburse Delta Dental for benefit claims paid as stated in Article 3.2 of this Agreement.

5.4. Delta Dental will provide periodic reports to Plan Sponsor at a mutually agreeable frequency. Samples of standard reports are provided in Attachment 4. Delta Dental may charge for production of non-standard reports as agreed to in advance by Plan Sponsor.

5.5. Delta Dental will maintain acceptable practices to prevent payment of fraudulent or non-valid claims.

5.6. In the event Delta Dental inadvertently overpays a benefit, then Delta Dental will attempt to recover the overpayment from the patient or dentist. Attempts may include a deduction from future benefit amounts payable on any covered family member.

5.7. Upon discovery of clerical errors or delays receiving enrollment data, Administrative Services Fees will be adjusted retroactively up to a maximum of three (3) months.

5.8. Delta Dental will be the "appropriate named fiduciary" of the Plan for purposes of denial and/or review of denied claims under the Plan. In exercising its fiduciary responsibility, Delta Dental will have discretionary authority to verify eligibility for coverage, to determine the amount of benefits for each claim received and to construe the terms of the Plan. Delta Dental's decision on any claim will be final.

ARTICLE 6. AMENDMENT, RENEWAL, OR TERMINATION

6.1. If during the Contract Term, any new tax is imposed on Delta Dental by any government agency on the amount of fees or the rate of an existing tax, Delta Dental fees will be increased by the amount of such new tax or increased taxes.

6.2. Delta Dental may terminate this Agreement due to the events described in Articles 6.3 through 6.7. If Delta Dental intends to terminate according to the provisions herein, Delta Dental will give Plan Sponsor a ninety (90) day notice of cancellation. If Delta Dental intends to terminate, according to the provisions herein, this Agreement, Delta Dental will give Plan Sponsor a ninety (90) day written notice of cancellation.

6.3. In the event payments described in Articles 3.1 and 3.2 are not paid by Plan Sponsor when due, Delta Dental may give written notice that payment is due and, if such payment is not received ten (10) calendar days thereafter, Delta Dental may, at its option, terminate all further administrative services and be released from all further obligations hereunder. Cancellation of this Agreement is effective on the last date for which payments are received.

6.4. If this Agreement is canceled for any cause, Delta Dental is not required to authorize payment for services incurred or submitted for a payment date which will occur beyond the Agreement cancellation date, or for any service date for which Plan Sponsor payments have not been received by Delta Dental. Administrative fees and services for run-out claims shall be negotiated at the time of cancellation, if Plan Sponsor desires such services.

6.5. If Delta Dental cancels this Agreement due to non-payment of administrative fees or claim reimbursements, Delta Dental reserves the right to approve or deny reinstatement of service upon receipt of past-due payment.

6.6. If this Agreement is canceled by Delta Dental for any cause stated herein, Plan Sponsor will be liable for any unpaid Administrative Fees or claims reimbursement owed on the date this Agreement is canceled as provided herein.

6.7. If Plan Sponsor intends to change benefits, administration of benefits or terms of this Agreement to be effective at the beginning of a new benefit year, Plan Sponsor will give Delta Dental a ninety (90) day advance written notice.

6.8. If Plan Sponsor cancels this Agreement for any cause, Plan Sponsor will give Delta Dental a thirty (30) advance written notice.

6.9. If Plan Sponsor cancels this Agreement for any cause, Plan Sponsor will be liable for any unpaid Administrative Fees or claims reimbursement due through the effective date of the cancellation.

6.10. Plan Sponsor will give notice to Plan Participants of Agreement termination.

6.11. Delta Dental reserves the right to terminate this Agreement for fraud or if the Plan Sponsor ceases to be domiciled or headquartered in New Mexico, including but not limited to bankruptcy, by giving the Plan Sponsor thirty (30) days written notice.

ARTICLE 7. GENERAL PROVISIONS

7.1. Entire Agreement. The Services Agreement and this This Agreement, including the attachments listed in Article 8, is the entire Agreement between the parties. No agent has the authority to change this Agreement or waive any of its provisions. This Agreement shall be subject to amendment or modification by mutual written Agreement between Delta Dental and Plan Sponsor.

7.2. Severability. If any part of this Agreement or an amendment of it is found by a court, or other authority to be illegal, void, or not enforceable, all other portions of this Agreement shall remain in full force and effect.

7.3. Conformity with State Laws. The laws of the State of New Mexico, where this Agreement was entered into and is to be performed, shall govern all legal questions about this Agreement. Any part of this Agreement which, on its effective date, conflicts with the laws of New Mexico is hereby amended to conform to the minimum requirements of such laws.

7.4. Legal Actions. No action at law or in equity shall be brought to recover on this Agreement before sixty (60) days after proof of loss has been filed in accordance with requirements of this Agreement, nor shall an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by this Agreement.

7.5. Publications About Plan. Plan Sponsor and Delta Dental agree to consult concerning all material published or distributed relating to this Agreement. No such material shall be published or distributed which is contrary to the terms of this Agreement. Plan Sponsor agrees to obtain prior approval from Delta Dental for use of its name and/or logo when identifying Delta Dental's services, networks and products.

7.6. Notice. All formal notice under this Agreement must be in writing and sent by first-class United States mail, overnight delivery service, or personal delivery. Notice by United States mail will be effective forty-eight (48) hours after mailing with fully prepaid postage. Notices shall be sent to the addressee party at the following address:

If to Plan Sponsor:
Kat Brophy
Benefits and Pension Manager
County of Los Alamos
1000 Central Ave Ste. 230
Los Alamos, NM 87544

If to Delta Dental:
JoLou Ottino-Trujillo
VP Sales & Marketing
Delta Dental Plan of New Mexico, Inc.
2500 Louisiana Boulevard N.E., Suite 600
Albuquerque, New Mexico 87110

7.7. Indemnification. Delta Dental shall indemnify, defend and hold harmless Plan Sponsor and its employees and agents, against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Delta Dental's negligent performance or non-performance of its obligations under this Agreement.

7.8. Reliance on Plan Sponsor's Data. Delta Dental's performance of services pursuant to this Agreement is dependent upon Plan Sponsor's submission of timely, accurate and complete information as required by Delta Dental. Plan Sponsor agrees to furnish such information. Plan Sponsor understands that failure to submit such information accurately and completely to Delta Dental within any requested time frames may delay or prevent access to the services provided pursuant to this Agreement. Plan Sponsor agrees that

Delta Dental may rely on such information in performing its services pursuant to this Agreement and that Plan Sponsor is solely responsible for its accuracy. Delta Dental may use data provided by Plan Sponsor for statistical, reporting or other related commercial purposes in a manner that will not disclose the identity or any other confidential information of any person.

7.9. Limitation of Services. Plan Sponsor agrees that: (a) Delta Dental does not provide, direct or control the provision of medical/dental services to Plan Participants; (b) the provision of contracted provider information in any medium by Delta Dental is not the provision of medical/dental diagnostic or treatment services, medical/dental advice or health advice; (c) all decisions regarding medical/dental services are made solely by the Plan Participant and the practitioner rendering medical/dental services to a Plan Participant and the results thereof are solely within the control of the provider of such medical/dental services and the Plan Participant(s); and (d) execution of this Agreement and the performance of its obligations does not constitute an undertaking by Delta Dental to render any medical/dental services, or to assume or guarantee the results thereof to Plan Participants, or to guarantee that medical/dental services will be rendered in accordance with generally accepted standards or procedures.

7.10. Subrogation. The Plan Sponsor shall retain all subrogation rights resulting from claims paid by Delta Dental. In the event the Plan Sponsor elects to pursue a subrogation matter, Delta Dental shall provide reasonable assistance to the Plan Sponsor. Such assistance shall be limited to providing the Plan Sponsor with documents, records and demand letters.

7.11. Change of Law. If, based on the issuance of a ruling, order, interpretation or determination by a court or government agency or the promulgation or the taking effect of a law, regulation, or amendment to the same, Delta Dental, in good faith, determines that in order to comply with such changes in law, it will be necessary to increase the fees for services set forth in Article 1, or otherwise pursuant to this Agreement or the arrangements contemplated herein, then Delta Dental agrees to provide ninety (90) days notice of the effective date of such fee revision and to substantiate the request with any pertinent documents and records of Delta Dental related to the proposed change.

7.12. Assignment and Delegation. Delta Dental may delegate to its affiliated entities, in whole or in part, its rights or duties under its various administrative or provider service Contracts with Plan Sponsor provided that such delegation will not relieve Delta Dental of any liability for its obligations under this Agreement.

7.13. Independent Contractors. In performing services under this Agreement, Delta Dental performs all acts as an independent Contractor and not as an officer, employee or agent of Plan Sponsor or any plan administrators (if other than Plan Sponsor) or specific benefit plan. Nothing in this Agreement shall be construed to mean that Plan Sponsor retains any control over the manner and means of how Delta Dental performs the services contracted for herein, but only a right to review the results of the work performed. Delta Dental does not assume any responsibility for any act, omission or breach by a fiduciary or for the adequacy of funding of the benefit plan, and Delta Dental is not, and shall not, be deemed to be an insurer, underwriter or guarantor with respect to any benefits payable under any such benefit plan.

7.14. No Third-Party Beneficiaries. This Agreement is entered into by and between the Parties hereto solely for their benefit. The Parties have not created or established any third-party beneficiary status or rights in any person or entity not a party hereto including, but not limited to, any client, Plan Participant, provider, subcontractor or other third-party, and no such third-party will have any right to enforce any right or enjoy any benefit created or established under this Agreement.

ARTICLE 8. ATTACHMENTS

8.1. These documents are attached to this Contract and made a part of it:

Attachment 1: Summary of Dental Plan Benefits

Attachment 2: Dental Benefit Handbook

Attachment 3: Business Associate Agreement

Attachment 4: Delta Dental Standard Quarterly Reporting Package

Attachment 5: Performance Guarantees

Attachment 1
AGR20-04

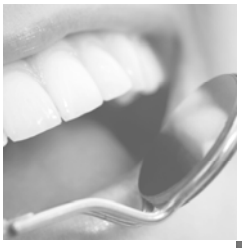
Delta Dental of New Mexico
2500 Louisiana Blvd NE Suite 600
Albuquerque, NM 87110
(505) 855-7111
1-877-395-9420
www.deltadentalnm.com

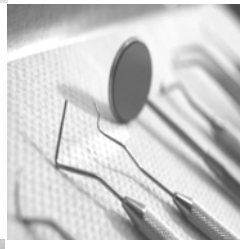
DELTA DENTAL®

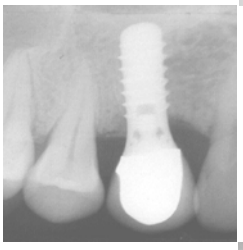
Attachment 2
AGR20-04

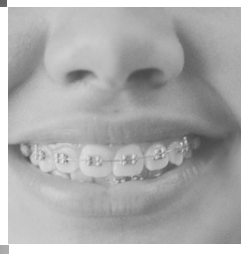
County of Los Alamos Dental Benefit Handbook

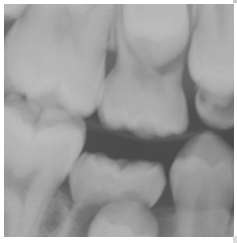
For Plan Participants

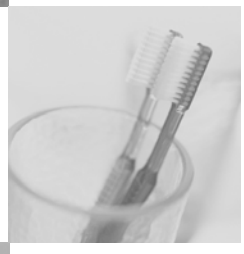


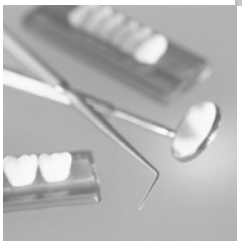












Featuring the

Delta Dental PPO℠ Point of Service Network

Plan Benefits Administered by Delta Dental of New Mexico

Attachment 2
AGR20-04

Attachment 2
AGR20-04

Delta Dental PPO℠ Point of Service

Welcome to the growing number of people who receive dental coverage administered by Delta Dental of New Mexico (Delta Dental).

This Dental Benefit Handbook, along with the Summary of Dental Plan Benefits, describes important Plan provisions.

Benefits under this Plan are provided by a Plan Sponsor for the exclusive benefit of eligible persons and their qualified dependents. The Plan Sponsor established the Plan as a self-funded dental Plan for the purpose of providing dental coverage and reserves the right to change or amend any or all provisions of the Plan and to terminate the Plan at any time. Any modification of the Plan will apply to all persons who are covered by the Plan at the time of such change.

Delta Dental has been selected by the Plan Sponsor to process claims under the Plan. Delta Dental does not serve as an insurer, but as a claims processor. Claims for benefits are sent to Delta Dental for benefit determination and claims payment. Delta Dental also administers enrollment, customer service, and the Delta Dental provider network(s) selected by the Plan Sponsor. Delta Dental has a contractual agreement to provide claims and other administrative services on behalf of the Plan Sponsor, but the Plan Sponsor, not Delta Dental, has sole responsibility for providing dental coverage under the Plan.

This Handbook, along with all supporting documentation and lists of participating New Mexico dentists, is always available at www.deltadentalnm.com. Please take time now to become familiar with your dental coverage. For answers to questions about benefits, please call:

Delta Dental of New Mexico
Customer Service Department
(505) 855-7111
or
toll-free (877) 395-9420

Good oral health is an important part of good general health. The Plan is designed to promote regular dental visits. Take advantage of this Plan by calling a Delta Dental dentist today for an appointment.

Table of Contents

I. Eligibility and Enrollment

A. Determining Eligibility

1. Individuals who meet one of the following qualifications and enroll in the Plan are eligible.

    a. Primary Plan Participant:

        i. an employee who works the minimum number of hours per week and/or satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Plan Sponsor.

        ii. any other person who satisfies the eligibility criteria for individual enrollment and the Eligibility Waiting Period as specified by the Plan Sponsor.

    b. A dependent of the Primary Plan Participant defined as:

        i. spouse as defined by New Mexico State Law;

        ii. unmarried children from birth through the end of the month of their twenty-fifth (25th) birthday who are primarily dependent on the Primary Plan Participant for support, unless otherwise indicated in the Summary of Dental Plan Benefits.

        iii. unmarried children age twenty-five (25) or older who cannot support themselves because of mental or physical impairment that began before age twenty-five (25) and are dependent on the Primary Plan Participant for support and maintenance. Proof of these facts must be given to the Plan within thirty-one (31) days if requested.

        iv. Please refer to your Summary of Dental Plan Benefits to verify age limitations that may apply to specific dental treatment and to the "Eligibility Provisions" to verify the dependent child age limitation.

2. The definition of "children" for the purposes of coverage under this dental Plan is:

    a. natural child(ren);

    b. newly born child(ren);

    c. stepchild(ren);

    d. child(ren) of a non-custodial spouse of any Primary Plan Participant;

    e. child(ren) for whom the Primary Plan Participant is the legal guardian;

    f. legally adopted child(ren), including children placed with a Primary Plan Participant or spouse for adoption. Coverage shall apply without any pre-existing benefit restrictions;

    g. foster child(ren) living in the same household as a Primary Plan Participant or spouse as a result of placement by a state licensed placement agency;

    h. dependent child(ren) required by a Qualified Medical Child Support Order (QMCSO) or a court or administrative order are also eligible for coverage without regard to Open Enrollment restrictions.

3. The following persons are not eligible: spouses or children in military service, and any individuals not defined as eligible above.

B. Enrollment Requirements

1. Eligible persons and their eligible dependents must enroll to be covered under the Plan. Unless required by law, eligible dependents may enroll only if the person who is eligible to be a Primary Plan Participant enrolls. Enrollments must be completed and received within thirty-one (31) days of the eligibility date.

2. Newly eligible Primary Plan Participants and dependents may enroll in accordance with their dates of eligibility.

3. A Primary Plan Participant may elect to enroll eligible dependents under the following conditions:

    a. eligible dependents must be enrolled at the time the Primary Plan Participant becomes enrolled, or within thirty-one (31) days from the date they become dependents, or within thirty-one (31) days of loss of other dental coverage, or during an Open Enrollment period;

    b. a Primary Plan Participant may not also enroll as a dependent under the same employer's plan;

    c. a dependent may enroll as the enrollee of only one Primary Plan Participant;

    d. newly born dependents become eligible on the date of birth and may be enrolled on the Group's effective date, within thirty-one (31) days of birth, or at Open Enrollment.

4. The Plan will allow an annual Open Enrollment period for all eligible persons of the Plan Sponsor. Open Enrollment is a period of time specified by the Plan Sponsor to allow eligible employees and/or other persons eligible for individual coverage and/or their dependents to enroll in the Plan or to cancel coverage under the Plan for the renewed contract period. Open Enrollment changes are effective the first day of the Plan Sponsor's renewed contract period.

5. If a person who is eligible to be a Primary Plan Participant does not elect coverage when first eligible, he/she may only enroll during the next Open Enrollment period. If that person elects not to enroll himself/herself or their dependents, a waiver must be signed on the enrollment form at the time of initial eligibility. For individuals waiving due to other dental coverage, this waiver does not affect eligibility for enrollment within thirty-one (31) days if a loss of coverage occurs in the future. Proof of loss of other dental coverage must be provided if requested.

C. Effective Dates of Coverage

1. Unless otherwise approved by the Plan and indicated on the Summary of Dental Plan Benefits, coverage for a Primary Plan Participant becomes effective on the first day of the month following the Primary Plan Participant's date of eligibility.

2. Coverage for newly born child(ren) will become effective on the date of birth, if enrolled within thirty-one (31) days, but not before the coverage date applicable to the Primary Plan Participant.

3. Coverage for enrolled dependents, except as noted in paragraph two (2) above, becomes effective on the same date as the Primary Plan Participant or on the first of the month following the dependent's date of eligibility.

4. The Plan must receive notification of any change of eligibility status within thirty-one (31) days of a change in eligibility status or a qualifying event. The corresponding change in coverage will become effective on the first day of the following calendar month.

D. Re-Enrollment After Voluntary Cancellation of Coverage

1. A Primary Plan Participant may cancel primary or dependent coverage during an annual Open Enrollment period. Re-enrollment is not available until the next annual Open Enrollment period or upon subsequent loss of coverage.

2. Re-enrollment in this Plan between Open Enrollment periods after voluntary cancellation of coverage is not allowed for any reason other than the loss of other dental coverage or another qualifying event. Re-enrollment and proof of loss of other dental coverage must be provided if requested.

II. How the Delta Dental PPO℠ Point of Service Plan Works

This section describes how your plan is designed, how you access your benefits, and the effect of your dentist selection. If you have any questions regarding how your plan works, please call Delta Dental Customer Service at (505) 855-7111 or toll-free (877) 395-9420.

A. Delta Dental Provider Networks Information

1. **Delta Dental PPO℠ Point of Service Provider Network**

   a. Delta Dental PPO Point of Service is designed to offer the greatest level of savings while still providing access to the largest nationwide network, Delta Dental Premier®.

   b. Delta Dental PPO℠ provider network is a subset of the Delta Dental Premier provider network. Delta Dental PPO providers have agreed to the deepest discounts. Members should select a Delta Dental PPO dentist to ensure the lowest out-of-pocket costs.

   c. Copayment can vary based on network selection. Refer to your Summary of Dental Plan Benefits for the copayment applicable to each network.

2. **Benefit Payment is Based on the Dentist Selected**

   a. You have the lowest out-of-pocket costs when selecting a Delta Dental PPO Participating Dentist.

   b. Delta Dental does not require that you pre-select a dentist and does not guarantee that a particular dentist will be available. Each enrolled person in your family may choose a different dentist.

3. **Delta Dental PPO Participating Dentists**

   a. You receive the highest level of benefits and lowest out-of-pocket costs when you visit a Delta Dental PPO Participating Dentist.

   b. Delta Dental PPO dentists have agreed to accept the Maximum Approved Fee from Delta Dental as payment in full and will not balance bill you above this amount.

   c. You will be responsible for any copayment and deductible (if applicable) for covered services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

4. **Delta Dental Premier Participating Dentists**

   a. By selecting a Delta Dental Premier Participating Dentist, you will be responsible for any copayment and deductible (if applicable) for covered services up to the Delta Dental Premier Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

   b. Copayment amounts may be higher when selecting a Delta Dental Premier dentist.

5. **Claims**

   Delta Dental PPO and Delta Dental Premier dentists will submit your dental claims to Delta Dental for processing. Delta Dental will send payment directly to Delta Dental dentists.

B. Accessing Benefits

To use this Plan, follow these steps:

1. Read this Handbook and the Summary of Dental Plan Benefits carefully to become familiar with your benefits, Delta Dental's method of payment on behalf of the Plan, and the provisions of this Plan.

2. Make a dental appointment and tell the dental office that dental coverage is under this Plan. If the office is not familiar with the coverage applicable to this Plan or has questions regarding this Plan, the dental office may contact the Delta Dental Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420.

3. Following dental treatment, a claim needs to be filed with Delta Dental. All participating Delta Dental dentist offices will file the claim directly with Delta Dental. Non-participating dentists may require patients to file their own claims. Claims for benefits must be submitted to Delta Dental in writing within twelve (12) months from the date services were provided. Failure to submit a claim within the time limitation shall not void or reduce the claim if it is shown it was not reasonably possible to submit within the twelve (12) months, and that the claim was submitted as soon as reasonably possible. If Delta Dental does not respond within fifteen (15) days to a request to furnish a dental claim form, the requirements for claims submission shall be deemed to have been met upon the submission to Delta Dental.

4. Plan Participants are responsible for filing claims for services received from a non-participating dentist outside of the United States. A claim form, including the "Patient Section," must be completed. Prior to submission to Delta Dental, the dental office providing services must complete an itemization of services that includes tooth number, if applicable, a description of each individual service, a date of service, a fee for each individual service, and a signature by the dentist.

   If the services performed outside of the United States are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image of the area must be obtained prior to the service being considered for benefits. Plan Participants are responsible for obtaining the necessary documentation for services provided, for filing a claim with Delta Dental, and for payment to the dentist at the time services are performed.

   Delta Dental will calculate foreign currency benefit payments based on published currency conversion tables that correspond to the date of service.

5. Completed claim forms should be submitted to Delta Dental, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110. The Delta Dental Customer Service Department is available Monday through Friday, 8:00 a.m. – 4:30 p.m. (Mountain Time) at (505) 855-7111 or toll-free (877) 395-9420.

6. Within thirty (30) days of receiving a valid claim, Delta Dental will make available an Explanation of Benefits which records Delta Dental's benefit determination, any payment made on behalf of the Plan by Delta Dental, and any amount still owed to the dental provider. The Explanation of Benefits will be made available to the Primary Plan Participant, or other appropriate beneficiary, and to the treating dentist if a Delta Dental Participating Dentist. The thirty (30) day period for claim determination may be extended by an additional fifteen (15) days if matters beyond the control of Delta Dental delay benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial thirty (30) day period.

7. If a claim for benefits is reduced or denied, the Explanation of Benefits will state the reason for the adverse determination. Should a Plan Participant believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the steps described in Section V, "Claims Appeal."

8. You may appoint an Authorized Representative to make contact with Delta Dental on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue. To request a form to designate your Representative, contact Delta Dental by visiting www.deltadentalnm.com, calling the Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420, or mailing a letter to 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110. Once you have appointed an Authorized Representative, Delta Dental will communicate directly with your Representative.

9. For questions and assistance regarding your coverage, you may contact the Plan Sponsor or call Delta Dental's Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420. You may also write to Delta Dental's Customer Service Department at 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110. When writing to Delta Dental, please include your name, the Group's name, your member ID number, and your daytime telephone number.

10. Pre-Treatment Estimates – A pre-treatment estimate of benefits provides both the patient and the dentist with an estimate of the benefit levels, maximums, and limitations that may apply to a proposed treatment plan. Most importantly, the Plan Participant's share of the cost will be estimated. A pre-treatment estimate is not required to receive payment unless specified on the Summary of Dental Plan Benefits, but it otherwise allows you to know what services may be covered before your dentist provides them. Your dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment. You and your dentist should review your pre-treatment estimate before treatment. Once treatment is complete, the dental office will submit a claim to Delta Dental for payment on behalf of the Plan.

    a. A pre-treatment estimate is for informational purposes only and is not required before you receive 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 received. It is not a guarantee of future dental benefits or payment.

    b. 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 Benefit Amount, 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 for benefits or a preauthorization, precertification, or other reservation of future benefits. Dental offices are familiar with the pre-treatment estimate of benefits procedures and will gladly provide this service to their patients.

C. Out-of-Pocket Expenses

This Plan is designed for cost sharing between the Plan Participant and the Plan Sponsor for the services provided by a dental provider.

1. **Deductible**
   This Plan may require Plan Participants to pay a portion of the initial expense toward some covered services in each benefit period. When applicable, the amount of this deductible is stated in the Summary of Dental Plan Benefits.

2. **Patient Copayment**
   The patient copayment is the percentage of covered services for which the Plan Participant is responsible for payment to the dental provider. The amount of patient copayment will vary depending on the level of benefits for the particular dental treatment and the selection of a participating or a non-participating provider as described in the accompanying Summary of Dental Plan Benefits.

3. **Maximum Benefit Amount**
   The Plan will pay for covered services up to a maximum amount for each Plan Participant for each benefit period. Plan Participants are responsible for payment of amounts due for any dental services that exceed the maximum benefit applicable in the benefit period. The Maximum Benefit Amount is stated in the Summary of Dental Plan Benefits.

D. Clinical Review

1. All claims are subject to review by a dental consultant. A dental consultant is an actively practicing dentist who has no affiliation or connection with Delta Dental other than as an independent consultant or a Delta Dental Participating Dentist.

2. Payment of benefits may require that a Plan Participant be examined by a licensed dental consultant or an independent licensed dentist.

3. Delta Dental may require additional information prior to approving a claim. All information and records acquired by Delta Dental will be kept confidential.

E. To Whom Benefits Are Paid

1. On behalf of the Plan, Delta Dental will pay a participating provider directly for covered services rendered. The Plan Participant is responsible for paying the provider directly for any copayment, deductible, and for any non-covered services.

2. On behalf of the Plan, Delta Dental will pay a New Mexico non-participating provider when an assignment of benefits is received on the individual claim.

3. On behalf of the Plan, Delta Dental will pay a non-participating provider practicing outside the state of New Mexico when required by the Delta Dental Plan in that state, when an assignment of benefits is received on the individual claim.

4. All available benefits not paid to the dental provider shall be payable to the Primary Plan Participant or to the estate of the Primary Plan Participant.

5. On behalf of the Plan, Delta Dental must pay directly to the Human Services Department or Indian Health Services any eligible dental benefits under this Contract which have already been paid or are being paid by the Human Services Department or Indian Health Services on behalf of the Plan Participant under the State's Medicaid Program or Indian Health Program.

6. In cases of a Qualified Medical Child Support Order (QMCSO), on behalf of the Plan, Delta Dental will send benefit payments directly to participating providers. Payment of benefits for services obtained from non-participating providers will be directed in compliance with the valid order of judgment provided in the QMCSO.

F. Right to Recover Benefits Paid By Mistake

If, on behalf of the Plan, Delta Dental makes a benefit payment to the Primary Plan Participant or to a provider and the patient is subsequently determined as not eligible for all or part of that benefit, Delta Dental has the right to recover payment. If benefit payment is made under fraudulent, false, or misleading pretenses or circumstances, Delta Dental has the right to recover that payment, on behalf of the Plan. The right to recover a payment includes the right to deduct the amount paid from future dental benefits for any covered family member. An explanation of the payment being recovered will be provided at the time a deduction is made.

III. Benefits, Limitations, and Exclusions

Unless otherwise specified on the Summary of Dental Plan Benefits, the benefits, limitations, and exclusions described in this section apply to this Plan. A dental service will be considered for benefits based on the date the service is started. Benefits are subject to the processing policies of Delta Dental and the terms and conditions of the entire Contract. Refer to the accompanying Summary of Dental Plan Benefits for patient copayment amounts. In addition to the limitations applicable to each type of service, refer to "General Limitations and Exclusions" for a detailed list of other applicable Plan exclusions.

A. Diagnostic and Preventive Services

Diagnostic: Procedures to aid the dentist in choosing required dental treatment (patient screenings, oral examinations, diagnostic consultations, diagnostic casts, clinical oral evaluations, and radiographic images).

Palliative: Minor, non-definitive emergency treatment to temporarily relieve pain.

Preventive: Brush biopsy and related lab tests, cleanings, application of topical fluoride, space maintainers, and sealants. Periodontal maintenance is considered to be a cleaning for benefit determination or payment purposes.

B. Limitations on Diagnostic and Preventive Services

1. Benefit for patient prediagnostic screenings is limited to once in a calendar year. A separate fee for patient assessment is disallowed.
2. Brush biopsies are limited to once in a twelve (12) month period. A separate fee for interpretation is disallowed.
3. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams, clinical oral evaluations, routine cleanings and periodontal maintenance, and topical fluoride treatment are limited as shown in the Summary of Dental Plan Benefits.
4. Enrollees under the age of fourteen (14) are limited to routine child cleanings. Enrollees age fourteen (14) and over will be considered adults for the purpose of determining benefits for cleanings.
5. A separate fee for periodontal maintenance may be disallowed within three (3) months of other periodontal therapy provided by the same dentist or dental office, as determined by clinical review.
6. Full mouth debridement is only a benefit when necessary to enable comprehensive evaluation and diagnosis and is limited to once per lifetime.
7. The Plan will benefit a complete series of radiographic images as stated in the Summary of Dental Plan Benefits. A panoramic radiographic image with or without bitewing images is considered a complete series of radiographic images. Images exceeding the diagnostic equivalent of a complete series of radiographic images will be disallowed when taken on the same date of service. Bitewing radiographic images exceeding the diagnostic equivalent of a complete series of radiographic images will be disallowed when taken on the same date of service.

8. Emergency palliative treatment does not include services and supplies that exceed the minor treatment of pain. Benefit is limited to radiographic images and tests necessary to diagnose the emergency condition.

9. Services for diagnostic casts, oral/facial photographic images, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered. A separate fee for image interpretation is disallowed.

10. Pulp tests are a benefit per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are disallowed as part of any other definitive procedure on the same day by the same dentist or dental office except for limited oral evaluation (problem focused), palliative treatment, radiographic images, and protective restorations.

11. Benefits for sealants are limited to permanent molars free from occlusal restorations and a covered service for enrollees as stated on the Summary of Dental Plan Benefits.

12. A separate fee for the replacement or repair of a sealant by the same dentist or dental office is disallowed within two (2) years of the initial placement.

13. An age limitation may apply to services related to space maintainers. Please refer to the Summary of Dental Plan Benefits for applicable age limitations.

14. Benefits for space maintainers are limited to once per lifetime per site. A separate fee for the removal of a space maintainer by the same dentist or dental office who placed the initial appliance is disallowed. Removal of a space maintainer by a different dentist or dental office is a benefit once per space per lifetime.

15. A separate fee for the recementation, re-bond, or repair to a space maintainer by the same dentist or dental office is disallowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation, re-bond, or repair is a benefit once per twelve (12) month period.

16. Preventive restorations are not a benefit.

17. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

C. Restorative Services

Restorative services are amalgam, resin-based composite restorations (fillings), or stainless steel and prefabricated stainless steel restorations. These covered services are a benefit for the treatment of visible destruction of the hard tooth structure resulting from the process of decay or injury.

D. Limitations on Restorative Services

1. A separate fee for the replacement of a restoration or any component of a restoration on a tooth for the same surface by the same dentist or dental office is disallowed if done within twenty-four (24) months of the initial service.

2. When multiple restorations involving multiple surfaces of the same tooth are performed, benefits will be limited to that of a multi-surface restoration. A separate benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth subject to clinical review.

3. Unless listed on the Summary of Dental Plan Benefits, resin restorations in posterior teeth are limited to bicuspid and maxillary first molars. On all other teeth, they are considered optional services and are limited to the equivalent amalgam restoration benefit.
4. Prefabricated resin crowns are a benefit for primary anterior teeth only.
5. Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the benefit for the equivalent amalgam/resin filling procedure.
6. Services for metallic, porcelain/ceramic, or composite/resin onlays are subject to clinical review, and limitations on optional services may apply.
7. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered.
8. Separate fees for more than one (1) pin per tooth or a pin performed on the same date of service as a build-up are disallowed. A separate fee for the replacement of pin retention on the same tooth, by the same dentist or dental office, within twenty-four (24) months is disallowed.
9. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

E. Basic Services

Anesthesia: Intravenous sedation and general anesthesia.

Endodontics: The treatment of teeth with diseased or damaged nerves (for example, root canals).

Extractions: Surgical and non-surgical extractions.

Oral Surgery: Oral surgery including oral maxillofacial surgical procedures of all hard and soft tissue of the oral cavity.

Periodontics: The treatment of diseases of the gums and supporting structures of the teeth.

F. Limitations on Basic Services

1. Evaluation for deep sedation or general anesthesia is disallowed when billed in conjunction with an evaluation by the same dentist or dental office.
2. Intravenous (IV) sedation and general anesthesia are not benefits for non-surgical extractions and/or patient apprehension.
3. Intravenous (IV) sedation and general anesthesia are benefits only when administered by a licensed dentist in conjunction with specified surgical procedures, subject to clinical review and when medically necessary.
4. Nitrous oxide and non-intravenous conscious sedation are not covered benefits.
5. Benefits for pulpal therapy procedures are limited to once in a twenty-four (24) month period.
6. A separate fee is disallowed for pulp therapy procedures when performed on the same day, by the same dentist or dental office, as other surgical procedures involving the root.
7. A separate fee is disallowed for a pulp cap placed on the same day as a restoration or within twenty-four (24) months of a pulp cap placed on the same tooth by the same dentist or dental office.
8. A pulpotomy or pulpal debridement is a benefit once per tooth per lifetime.

9. Pulpotomies and pulpal therapy procedures are limited to primary teeth.
10. Benefits for certain oral surgery procedures are subject to the receipt of an operative report and clinical review, and may be reduced by benefits provided under the patient's medical benefits coverage, if applicable.
11. Root canal therapy in conjunction with overdentures is not a benefit.
12. Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same dentist or dental office, within twenty-four (24) months, is considered part of the original procedure and a separate fee is disallowed.
13. Apexification benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is disallowed if performed by the same dentist or dental office within twenty-four (24) months of root canal therapy.
14. Endodontic endosseous implants are not a benefit.
15. Tooth transplantation, including re-implantation, is not a benefit.
16. Periodontal scaling and root planing are a benefit once per quadrant or site in a two (2) year period.
17. Periodontal surgeries, such as gingivectomy, gingival flap, osseous surgery, bone grafts, and tissue graft procedures are limited to once per site in a three (3) year period.
18. Gingivectomy or gingivoplasty to allow access for a restorative procedure is considered part of the restorative procedure.
19. A bone replacement graft, biologic materials, or guided tissue regeneration in conjunction with an apicoectomy, gingivectomy, crown lengthening, retrograde filling, root amputation, periradicular surgery, soft tissue grafts, subepithelial tissue grafts, extraction, implant site, ridge augmentation, anatomical crown exposure, wedge procedure, or an apically positioned flap is a specialized procedure and not a benefit.
20. Extra oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site is not a benefit.
21. Separate fees for crown lengthening in the same site are disallowed when charged by the same dentist or dental office within three (3) years.
22. Additional fees for more than two (2) quadrants of osseous surgery on the same day of service are disallowed.
23. Separate fees for postoperative visits and/or dressing changes by the same dentist or dental office performing the treatment are disallowed.
24. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

G. Major Services

Crown Build-Ups and Substructures: Benefits when necessary to retain a cast restoration due to extensive loss of tooth structure from caries, fracture, or endodontic treatment.

Crowns and Cast Restorations, Including Repairs to Covered Procedures: Benefits when a tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or resin filling.

Prosthodontics: Procedures for construction, modification, or repair of bridges and partial or complete dentures.

H. Limitations on Major Services

1. Replacement of cast restorations (including veneers, crowns, inlays, and onlays) and associated procedures (such as cores and substructures) on the same tooth are not a benefit if the previous placement is less than five (5) years old.
2. Inlays are not a covered service and will be optioned to an amalgam or resin restoration.
3. Veneers are not a covered service and will be optioned to a resin restoration.
4. Replacement of a bridge or denture is not a benefit if the previous placement is less than five (5) years old.
5. Services which are beyond the standard of care customarily provided, or not necessary to restore function, are limited to the benefit applicable to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
6. Cantilever bridges are beyond the standard of care customarily provided and are subject to clinical review.
7. Overdentures are not a covered service.
8. Substructures are only a benefit when necessary to retain a cast restoration due to the extensive loss of tooth structure from caries or fracture. Substructures are disallowed when enough tooth structure is present to retain a cast restoration.
9. The fee for a core build-up and/or substructures is disallowed when performed in conjunction with inlays, onlays, ¾ crowns, and veneers.
10. Posts and cores in addition to a crown are a benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are disallowed when these requirements are not satisfied.
11. A separate fee for the recementation, re-bond, or repair to crowns, inlays, onlays, post and core, veneers, or bridges within six (6) months of the original treatment by the same dentist or dental office is disallowed. After six (6) months, these services are a benefit once per twelve (12) months. Procedures to modify existing partials and dentures are considered construction of prosthesis versus the repair of prosthesis.
12. A pontic required due to spaces in excess of those resulting from the extraction of the normal complement of natural teeth is a special condition of that patient's mouth and is not a benefit.
13. A posterior fixed bridge and a partial denture are not benefits in the same arch. Benefit is limited to the allowance for a partial denture.
14. Temporary restorations and temporary prosthodontics are considered part of the final restoration. A separate fee by the same dentist or dental office is disallowed.

15. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to bicuspids and maxillary first molars. On all other teeth, they are considered optional services and benefits are limited to the equivalent metal crown or metal supported prosthetic benefit.
16. Maxillofacial prosthetics and related services are not a benefit.
17. Crowns, prosthodontics, and all related services are not benefits for enrollees under the age of sixteen (16).
18. Fees for full or partial dentures include any reline/rebase, adjustment, or repair required within six (6) months of delivery except in the case of immediate dentures. After six (6) months, adjustments to dentures are a benefit twice in a twelve (12) month period and relines or rebases are a benefit once in a three (3) year period.
19. Tissue conditioning is not a benefit more than twice per denture unit in a three (3) year period.
20. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

I. Major Services – Implants

Implants: Specified services, including repairs, and related prosthodontics.

J. Limitations on Implants

1. A separate fee for the recementation or repair to implants within six (6) months of the original treatment by the same dentist or dental office is disallowed. After six (6) months, these services are a benefit once per twelve (12) months.
2. Surgical placement of eposteal or transosteal implants is not a benefit.
3. Surgical placement of an endosteal implant is a benefit once per tooth per five (5) year period.
4. Implant supported prosthetics and/or abutment supported crowns are not a benefit if the previous placement is less than five (5) years old.
5. Implant retained or supported crowns and retainers with metallic alloy content less than high noble are not benefits.
6. Implant maintenance procedures are limited to twice in a benefit period.
7. Stress breaker, semi-precision, or precision attachments or the replacement of an implant/abutment supported prosthesis is considered an optional service and is not a benefit.
8. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same dentist or dental office, is disallowed. After twenty-four (24) months, this service is a benefit once per tooth per lifetime.
9. A separate fee is disallowed for a radiologic surgical implant index.
10. Temporary restorations, temporary implants, and temporary prosthodontics are considered part of the final restoration. A separate fee by the same dentist or dental office is disallowed.
11. Implants and all related services are not benefits for enrollees under the age of sixteen (16).
12. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

K. Orthodontic Services

Orthodontic Services means procedures performed by a dentist using appliances to treat poor alignment of teeth and their surrounding structure. The benefit determination for the Orthodontic Lifetime Maximum may include specific non-orthodontic procedure codes that are directly related, as determined by Delta Dental, to be part of an orthodontic treatment plan. Procedures directly related to Orthodontic Services will only be considered eligible expenses if benefits for Orthodontic Services apply.

Payment for charges that exceed the maximum benefit applicable to Orthodontic Services is the patient's responsibility. Refer to the Summary of Dental Plan Benefits to verify if this Plan includes coverage for Orthodontic Services along with specific and lifetime benefit provisions.

Diagnostic casts will be considered for payment at the Diagnostic and Preventive Services copayment level when performed in conjunction with covered Orthodontic Services. Payments for diagnostic casts are part of the Orthodontic Lifetime Maximum.

L. Limitations on Orthodontic Services

1. If the Plan Participant is already in orthodontic treatment, benefits shall commence with the first treatment rendered following the patient's effective date or any applicable benefit waiting period. Charges for treatment incurred prior to the patient's effective date are not covered.
2. Benefits are determined based on the total cost and total months of treatment.
3. Benefits will end immediately if orthodontic treatment is stopped.
4. Charges to repair or replace any orthodontic appliance are not covered, even when the appliance was a covered benefit under this or any other Plan.
5. Charges for radiographic images (except for cephalometric radiographic image) and extractions are not covered under Orthodontic Services.
6. Oral/facial photographic images and diagnostic casts are a benefit once per orthodontic treatment case. Additional fees for these procedures are disallowed when performed by the same dentist or dental office.
7. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

M. General Limitations and Exclusions

1. A waiting period prior to obtaining some services applies if stated on the Summary of Dental Plan Benefits. This means a Plan Participant is not eligible for benefits for those services until he/she has been continually enrolled under this Contract for the time frame stated in the Summary of Dental Plan Benefits.
2. Services for any covered procedures which exceed the frequency or age limitation shown on the Summary of Dental Plan Benefits are not eligible for benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.
3. Services beyond treatment that is considered the standard of care customarily provided are considered "optional or specialized services." These services may include the use of alternative techniques, special materials, and services of a cosmetic intent.
    a. If a Plan Participant receives optional or specialized services, benefits may be provided based on the customary or standard procedure. A determination of optional or

specialized services is not an opinion or judgment on the quality or durability of the service. The Plan Participant will be responsible for any difference between the cost of optional or specialized services and any benefit payable.

4. Charges for cone beam CT capture and interpretation services are not a benefit.
5. Treatment of injuries or illness covered by Workers' Compensation or Employers' Liabilities Laws or services received without cost from any federal, state, or local agencies are not a benefit.
6. Treatment to restore tooth structure lost from wear is not covered.
7. Cosmetic surgery or procedures are not covered.
8. Prosthodontic services or any single procedure started before the patient is covered under this Plan is not eligible for benefits.
9. Prescribed drugs, pain medications, desensitizing medications, and therapeutic drug injections are not covered unless part of a medically necessary TMD treatment plan and subject to approval by Delta Dental.
10. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dental or medical provider for treatment in any such facility are not covered services.
11. Orthodontic Services, or any services related to an orthodontic treatment plan, are not covered unless stated in the Summary of Dental Plan Benefits.
12. Treatment must be provided by a licensed dentist or a person who by law may work under a licensed dentist's direct supervision.
13. A separate charge for office visits, non-diagnostic consultations, case presentations, or cancelled or missed appointments is not covered.
14. Treatment to correct harmful habits is not covered.
15. A separate charge is disallowed for behavior management, infection control, sterilization, supplies, and materials.
16. Charges for services or supplies that are not necessary according to accepted standards of dental practice are not benefits.
17. Charges for services, supplies, or devices which are not a dental necessity are not benefits.
18. Services or supplies, as determined by Delta Dental, that are investigational or experimental in nature are not covered. This includes services and supplies required to treat complications from investigational or experimental procedures.
19. A hemisectioned tooth will not be benefited as two (2) separate teeth.
20. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a benefit.
21. Treatment to stabilize teeth is not a benefit.
22. Occlusal or athletic mouth guards and related services are not a benefit unless part of a medically necessary TMD treatment plan and subject to approval by Delta Dental.

23. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered. A tooth fracture or crack is defined as tooth structure that is mobile and/or separated from the natural tooth structure.

24. Charges for treatment of craze lines are not a benefit. A "craze line" is a visible micro-fracture located in coronal enamel that does not break or split the continuity of the tooth structure.

25. Sales tax is not a benefit.

26. Separate fees are disallowed for procedures which are routinely considered by Delta Dental to be part of another service, if performed by the same dentist or dental office on the same date of service.

27. Services or supplies excluded by the policies and procedures of Delta Dental, including the processing policies, are not a benefit.

28. Services or supplies for which no charge is made, 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 are not covered by the Plan.

29. Services or supplies received due to an act of war, declared or undeclared, are not a covered service.

30. Services for patients with specified medical conditions, or any services related to the specified medical conditions treatment plan, are not covered.

31. Implant services, or any services related to an implant treatment plan, are not covered unless stated in the Summary of Dental Plan Benefits.

32. Treatment of temporomandibular/craniomandibular disorders (TMD), or any services related to temporomandibular/craniomandibular disorders (TMD) treatment plan, are not covered.

33. Services or supplies that are not within the categories of benefits selected by the Plan Sponsor and that are not covered under the terms of this Handbook are not a benefit.

IV. Coordination of Benefits

Coordination of Benefits (COB) applies to this Plan when a Plan Participant 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.

A Plan Participant will provide Delta Dental with the information needed to administer COB. Delta Dental may release required information or obtain required information in order to coordinate the benefits of a Plan Participant.

A. Determining Which Plan is Primary

To determine which plan is primary, Delta Dental considers both which Plan Participant of a family is involved in a claim and the coordination provisions of the other plan. The primary plan is determined by the first of the following rules that applies:

1. **Medicaid or Indian Health Services** – The Plan is always the primary plan to any benefits payable by Medicaid or Indian Health Services.

2. **Non-Coordinating Plans** – If you have another plan that does not coordinate benefits, it will always be the primary plan.

3. **Hospital, Surgical/Medical, or Prescription Drug Plans** – These are the primary plan if the plan provides benefits for dental related services including but not limited to: treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery, the administration of general anesthesia, and temporomandibular joint disorder.

4. **Employee or Subscriber** – The plan that covers the Plan Participant other than as an enrolled dependent is primary. For example, the plan that covers you as the employee or subscriber, neither laid off nor retired, is the primary plan.

5. **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.

6. **Children with Parents Divorced or Separated**

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

    b. 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 5 above). If neither of these rules applies, the order will be determined as follows:

        i. First, the plan of the parent with custody of the child;

        ii. Then, the plan of the spouse of the parent with custody of the child;

        iii. Next, the plan of the parent without custody of the child; and

        iv. Last, the plan of the spouse of the parent without custody of the child.

7. **Laid-Off or Retired Enrollees**

    a. The plan that covers the enrollee as a laid-off or retired employee or as a dependent of a laid-off or retired employee.

8. **COBRA Coverage**

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

9. **Other Plans**

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

B. How This Plan Pays as Primary

When this Plan is the primary plan, the Plan will pay for covered services as if you had no other coverage.

C. How This Plan Pays as Secondary

When this Plan 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. However, the Plan may pay less than it would have paid as the primary plan if the balance is lower than that amount.

D. Right of Recovery

If Delta Dental pays more than it should have paid on behalf of the Plan, under this COB provision, it may recover the excess from one or more of:

1. The people it has paid or for whom it has paid;

    a. Insurance companies; or

    b. Other organizations.

V. Claims Appeal

A. Voluntary Appeal Procedure

1. A Plan Participant may request a review of a claim by following Delta Dental's claim appeal procedures. All of Delta Dental's claim appeal procedures are voluntary and are designed to provide a full and fair review of any adverse benefit determination. An adverse benefit determination means a denial, reduction, or termination of a benefit or a failure to make payment, in whole or in part, on a claim.

2. The decision as to whether to request a review or to appeal a claim will have no effect on the patient's right to any other benefits under the Plan. In addition, the following provisions are assured. The Plan Participant:

    a. will be notified in writing by Delta Dental of any adverse benefit determination and the reason(s) for the adverse determination;

    b. may submit written comments, documents, records, narratives, radiographs, clinical documentation, and other information relating to the claim which Delta Dental will take into consideration, whether or not such information was submitted or considered in the initial benefit determination;

    c. shall be provided, upon request and free of charge, reasonable access to and/or copies of all documents, records, and other information in the possession of Delta Dental that is relevant to the claim;

    d. may choose a representative to act on his or her behalf at the Plan Participant's expense;

    e. will not be charged any fees or costs incurred by Delta Dental as part of the voluntary appeals process;

    f. has one hundred eighty (180) days following receipt of a notification of an adverse benefit determination within which to appeal;

    g. will receive a response to the appeal from Delta Dental in writing within thirty (30) days of receipt of the request;

    h. is not required to file an appeal prior to arbitration or taking civil action;

    i. is assured that the review of any adverse benefit determination under appeal will not be conducted by the same person or a subordinate of the person who determined the initial adverse benefit determination.

B. Informal Claim Review Process

Most claim-related requests may be handled informally by calling the Delta Dental Customer Service Department at (505) 855-7111 or toll-free at (877) 395-9420. Plan Participants always have the opportunity to describe problems, submit explanatory information, and allow Delta Dental to correct errors quickly.

C. Formal Claim Appeal Process

If a Plan Participant disagrees with a benefit determination, a formal review of the claim may be requested by filing an appeal with Delta Dental within one hundred eighty (180) days following receipt of Delta Dental's notification of an adverse benefit determination. An appeal is a formal,

written request to change a previous decision made by Delta Dental. There are two (2) types of appeals: Appeal of Claim Processing Procedure and Appeal of Claim for Dental Treatment.

1. Appeal of Claim Processing Procedure means the Plan Participant is requesting a review of the application by Delta Dental of an administrative, procedural, or Plan benefit provision which resulted in an adverse benefit determination.

    a. An adverse benefit determination may be appealed by sending a request in writing to Delta Dental describing the reasons for requesting a review and including any additional information that the Plan Participant wishes to be considered.

    b. A Delta Dental representative, who is neither the individual who made the initial claim determination nor the subordinate of such individual, will conduct a review of the claim. The results of the review will be provided in writing to both the Plan Participant and to the treating dental provider, as appropriate.

2. Appeal of Claims for Dental Treatment is a request for a review of an adverse benefit determination that resulted from a clinical review conducted by a Delta Dental dental consultant. Three (3) voluntary options for appeal are available:

    a. The Plan Participant may appeal an adverse benefit determination by sending a request in writing to Delta Dental describing the reasons for the appeal and including any additional information the Plan Participant wishes to be considered. A dental consultant, who is neither the individual who made the initial claim determination nor the subordinate of that individual, will provide a full and fair subsequent and independent review of the claim.

        i. If the second consulting dentist determines the treatment was dentally necessary, Delta Dental will recalculate the claim for available benefits and send written notification of payment to the Plan Participant and the treating dentist. In the event the second consulting dentist also determines the treatment was not dentally necessary according to the terms of the Plan provisions or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send notification to the Plan Participant and to the treating dental provider, as appropriate.

    b. The Plan Participant may appeal an adverse benefit determination and request an independent oral examination by writing to Delta Dental, describing the reasons for the request, and including additional information the Plan Participant wishes to be considered. A dental consultant, who has neither been involved in previous determinations of the claim under review nor is a subordinate of that individual, will provide a full and fair independent review of the claim.

        i. If the second consulting dentist agrees the treatment was dentally necessary, Delta Dental will recalculate the claim for available benefits and send written notification of payment to the Plan Participant and the treating dental provider, as appropriate.

        ii. In the event the second consulting dentist determines the treatment was not dentally necessary according to the terms of this Plan or standard dental treatment, an oral examination will be scheduled with a mutually agreed upon licensed dentist. The fee for this oral examination will be the responsibility of Delta Dental and will not apply to the frequency limitations on exams under this Plan's benefit provisions. If that examining dentist agrees the treatment was dentally necessary, Delta Dental will recalculate the claim for available benefits

and send written notification of payment to the Plan Participant and the treating dentist. In the event the examining dentist determines the treatment was not dentally necessary according to the terms of this Plan or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send written notification to the Plan Participant and to the treating dentist, as appropriate.

c. The Plan Participant may appeal an adverse benefit determination and request an external peer review by the local or state dental society. Delta Dental will provide the Plan Participant with information on how to initiate the peer review process through the New Mexico Dental Association.

D. Grievance

No person shall be subject to retaliatory action by Delta Dental for any reason related to a grievance. All written appeals must be directed to Delta Dental, Attention: Claims Manager, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110.

VI. Termination of Coverage

A. When Coverage for a Plan Participant Ends

1. Unless otherwise stated in the Summary of Dental Plan Benefits, coverage ends on the last day of the month in which a Primary Plan Participant loses coverage due to:

   a. loss of eligibility;

   b. voluntary cancellation of coverage;

   c. cancellation of the Plan;

   d. entering an unapproved leave of absence. Upon return to work, coverage may resume as specified by the Plan Sponsor. An employee absent from work due to an approved leave of absence, including those governed by the "Family Medical Leave Act of 1993," may continue coverage without interruption during a leave period if the Plan Sponsor continues to report the employee as a Primary Plan Participant and premiums are paid on the enrollee's behalf.

2. An enrolled dependent loses coverage along with the Primary Plan Participant, or on the last day of the month in which dependent status is lost, whichever is earlier. Coverage for dependent children who reach age twenty-five (25) will automatically be terminated by Delta Dental the last day of the month in which the dependent child turns age twenty-five (25) unless Delta Dental receives proof of the dependent child's qualification for extended eligibility. Refer to the Summary of Dental Plan Benefits for any exceptions to the age twenty-five (25) limitation.

3. A Plan Participant and/or dependent may be eligible to continue coverage depending on the size of the Group and if certain conditions are met. Please refer to "Continuation of Coverage" in this Handbook.

B. When Payment for Claims Ends

If a Plan Participant loses coverage, Delta Dental will only pay claims, on behalf of the Plan, for covered services incurred prior to the loss of coverage. To be considered for payment, claims must be submitted to Delta Dental in writing within twelve (12) months after the services have been provided and while the Plan Sponsor's Administrative Services Contract is still in effect.

C. Termination of the Plan Sponsor's Administrative Services Contract with Delta Dental

In the event the Administrative Services Contract between the Plan Sponsor and Delta Dental is canceled for any reason, including non-payment of Delta Dental's administration fees or the Plan Sponsor's failure to fund claims on a timely basis, Delta Dental will discontinue providing administrative and claims processing services and access to the Delta Dental dentist network on the date concurrent with the termination of the Administrative Services Contract.

VII. Continuation of Coverage

A Plan Sponsor may be subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. This means that a Plan Participant may be entitled to continue coverage at their own expense under this dental Plan following certain qualifying events if certain conditions are met. To be eligible for continued coverage, the Plan Participant must be enrolled in this Plan on the day before the qualifying event occurs. The Plan Sponsor is responsible for providing Plan Participants with notification of COBRA continuation rights and for any/all administration related to those COBRA rights.

VIII. Subrogation and Right of Reimbursement

To the extent that this Plan provides or pays benefits for covered services, the Plan Sponsor may be subrogated to any right you or your eligible dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions.

In the event the Plan Sponsor elects to pursue a subrogation matter, Delta Dental shall provide reasonable assistance to the Plan Sponsor. Such assistance shall be limited to providing the Plan Sponsor with documents, records, and demand letters.

IX. Notice of Privacy Practices

Delta Dental Plan of New Mexico, Inc., recognizes the obligation to keep information about Plan Participants secure and confidential. Delta Dental does not sell information about Plan Participants to others. This notice is to help Plan Participants understand how Delta Dental may collect information, the type of information that may be collected, and what information may be disclosed about Plan Participants to nonaffiliated third parties. From time to time Delta Dental may amend this privacy policy. Delta Dental maintains appropriate physical, electronic, and procedural safeguards to maintain the confidentiality and security of nonpublic personal information. Access to nonpublic personal information is restricted to those who need to know the information in order to provide products or services to Plan Participants.

A. Categories of Information Collected

Non-public personal information from the following sources is collected and maintained:

1. Plan Participants: information Delta Dental receives on enrollment forms, change forms, and other correspondence;
2. The Plan Sponsor: information received from Plan Sponsor billings, change forms, and other correspondence;
3. Dental providers: information received such as dental treatments, fees for treatment, copayments collected, and chart records when necessary;
4. Insurance carriers: information received for coordination of benefits or eligibility-related issues;
5. Information received from a Plan Participant and/or the Plan Sponsor via the Internet.

B. Categories of Information Disclosed and to Whom Information May Be Disclosed

Delta Dental Plan of New Mexico, Inc., will not disclose non-public personal health or financial information concerning any persons covered under the Plan to third parties not affiliated with

Delta Dental, other than the Plan Sponsor except as necessary to process claims for dental services and as permitted by law.

On behalf of the Plan, Delta Dental may disclose, as permitted by law, the following kinds of non-public personal information about Plan Participants:

1. Information received from enrolled persons on applications or other forms;
2. Information about an enrolled person's transactions with Delta Dental or Delta Dental's business associates;
3. Non-public personal information about Plan Participants to the following types of third parties: dental providers, insurance companies, and non-affiliated third parties as permitted or required by law.

The Plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan Sponsor, as per the requirements of 45 CFR 164.504(f) of HIPAA, has agreed to:

1. Not use or further disclose health information protected under HIPAA ("PHI") other than as permitted or required by the Plan documents or as required by law;
2. Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose PHI for employment-related actions and decisions;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan;
5. Report to the Plan's designee any PHI use or disclosure that the Plan Sponsor becomes aware of that is inconsistent with the uses or disclosures provided for;
6. Make PHI available to an individual based on HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
10. Ensure that adequate separation between the Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and
11. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

X. Definitions

Administrative Fee(s): The fees from the Plan Sponsor due to Delta Dental for Plan administration.

Administrative Services Agreement or Contract: The Plan Sponsor Administrative Services Contract document, including Article I "Declarations," Dental Benefit Handbook, Summary of Dental Plan Benefits, and, if applicable, successor agreements or renewals initially or thereafter issued or executed.

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 Maximum Approved Fees determined by Delta Dental and considered for each dental procedure before application of copayment and deductible.

Benefit Period: The time period during which the deductible and benefit maximum accumulate and frequency limitations apply, as shown in the Summary of Dental Plan Benefits.

Benefits: The amount Delta Dental will pay on behalf of the Plan for covered dental services described in Section III, "Benefits, Limitations, and Exclusions," and in the Summary of Dental Plan Benefits.

Copayment: The percentage of the dental provider's approved fee due from the Plan Participant to the dental provider.

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 Handbook.

Deductible: The amount a Plan Participant or family must pay toward covered services before Delta Dental makes any payment for those covered services.

Delta Dental: Delta Dental of New Mexico or Delta Dental Plan of New Mexico, Inc.

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

Dental Benefit Handbook: This document. Delta Dental will provide benefits, on behalf of the Plan, as described in this Handbook. Any changes in this Handbook will be based on changes to the Administrative Services Agreement between Delta Dental and the Plan Sponsor.

Dental Consultant: An independent contractor paid by Delta Dental of New Mexico to conduct claims review. The review of dental insurance claims is defined in the practice of dentistry in the New Mexico Dental Practice Act. A Dental Consultant must be a licensed dentist as well as actively practicing dentistry.

Dental Necessity (Dentally Necessary): A service or supply provided by a dentist or other provider that has been determined by Delta Dental as generally accepted dental practice for the Plan Participant's diagnosis and treatment. Delta Dental may use dental consultants to determine generally accepted dental practice standards and if a service is a dental necessity. These services or supplies are in accordance with generally accepted local and national standards of dental practice, and not primarily for the convenience of the Plan Participant or provider. The services/supplies are the most appropriate that can safely be provided. The fact that a provider has performed or prescribed a service or supply does not mean it is a dental necessity.

Dentist: A duly licensed dentist, legally entitled to practice dentistry at the time and in the place services are provided.

Disallow: A fee for a service that is disallowed is not benefitted by Delta Dental, nor collectable from the patient by the Participating Dentist.

Enrolled Dependent: An eligible dependent of a Primary Plan Participant whose completed enrollment information has been received and approved for coverage.

Experimental/Investigational: A treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard dental treatment for the condition being treated or any items requiring federal or other government agency approval if such approval had not been granted at the time services were rendered. To be considered standard dental practice and not Experimental/ Investigational, the treatment must have met all five of the following criteria:

1. A technology must have final approval from the appropriate regulatory government bodies;
2. The scientific evidence as published in peer-review literature must permit conclusions concerning the effect of the technology on health outcome;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives; and
5. The technology must be attainable outside the investigational settings.

Group: The employer named on the Summary of Dental Plan Benefits.

Independent Licensed Dentist: A licensed dentist that is actively practicing dentistry.

Maximum Approved Fee: A system used by Delta Dental to determine the approved fee for a given procedure for a given Participating Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of: (a) the Submitted Amount; (b) 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; or (c) the maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances, 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 Benefit Amount: The maximum dollar amount Delta Dental will pay, on behalf of the Plan, in a benefit or lifetime period for covered services for each enrolled member.

Medical Necessity (Medically Necessary): Means that a dental item or service satisfies each of the following criteria: (a) is recommended by a dentist or other qualified dental professional practicing within the scope of his or her license who has personally evaluated the patient; (b) is essential to and provided for prevention, evaluation, diagnosis, or treatment of the patient's dental condition, disease, or injury; (c) is consistent with the symptoms, finding, and diagnosis related to the patient's dental condition, disease, or injury; (d) is clinically appropriate for diagnosis and treatment of the patient's dental condition, disease, or injury in terms of type, frequency, extent, site, and duration of the intervention; (e) is considered to be effective intervention for the patient's dental condition, disease, or injury which can reasonably be expected to have beneficial health outcomes that outweigh potential harmful effects; (f) is performed in accordance with relevant credible scientific evidence and generally accepted professional standards of care; and (g) is required for reasons other than the convenience of the patient or treating provider. Delta Dental may use dental consultants to determine medical necessity.

Non-Participating Approved Amount: The maximum fee allowed per procedure for services rendered by a non-participating dentist as determined by Delta Dental.

Non-Participating Dentist: A dentist who has not signed a contract with any Delta Dental Plan to participate in any of Delta Dental's provider networks. Non-participating dentists do not accept Delta Dental's maximum approved fees. Non-participating dentists may bill the patient the full submitted charge as well as any charges for disallowed services.

Open Enrollment: A period of time specified by the Plan Sponsor to allow eligible persons to enroll in this Plan or to cancel coverage under this Plan for the renewed contract period.

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.

Participating Dentist: A dentist who has agreed to abide by a Delta Dental Participating Dentist Agreement.

Plan Participant: An enrolled employee, enrolled dependent, COBRA-enrolled person, or other person who meets the conditions of eligibility outlined in Section I, "Eligibility and Enrollment," whose completed enrollment information has been received and approved by Delta Dental and for whom applicable administrative fees are paid.

Plan Sponsor: The employer or employee organization that establishes or maintains the Dental Benefit Plan.

Primary Plan Participant: An eligible employee or other person who meets the conditions of individual coverage eligibility outline in Section I, "Eligibility and Enrollment," whose completed enrollment information has been received and approved for coverage.

Pre-Treatment Estimate: A written estimate issued by Delta Dental that outlines dental benefits that may be available under your coverage for your proposed dental treatment. A pre-treatment estimate is voluntary and optional unless specified on the Summary of Dental Plan Benefits.

Processing Policies: Delta Dental's policies and guidelines used for pre-treatment estimates and payment of claims. The Processing Policies may be amended from time to time.

Provider: A legally licensed dentist, or any other legally licensed dental practitioner, rendering services within the scope of that practitioner's license.

Qualifying Event: A specific, qualified circumstance that alters the eligibility status of an employee or that person's dependents under this Plan. Qualifying events include but are not limited to: marriage, childbirth, divorce, and involuntary loss of other coverage. The changes a Primary Plan Participant or a dependent makes to coverage due to a qualifying event must be consistent with that particular event. Events may affect eligibility differently. Delta Dental must receive notification of any change of eligibility status within thirty-one (31) days of a qualifying event.

Services and Supplies: Those services, devices, or supplies that are considered safe, effective, and appropriate for the diagnosis or treatment of the existing condition. Covered services and supplies do not include experimental services, devices, or supplies. For the purposes of this Plan, Delta Dental reserves the right to make the final decision as to whether services, devices, or supplies are experimental under this definition.

Sound Natural Teeth: Those teeth that are either primary (A through T or AS through TS) or permanent (1 through 32 and 51 through 82) dentition that have adequate hard and soft tissue support.

Specialized Procedure: The term "Specialized Procedure" describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and it is not generally used when conventional methods are adequate.

Spouse: The individual legally married to a subscriber as determined and recognized by New Mexico state law.

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

Subscriber: The Primary Plan Participant, such as an employee, who is not enrolled as a dependent.

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

Temporomandibular Joint Disorder (TMD): A disorder and/or dysfunction associated with temporomandibular/craniomandibular structure.

This Plan: The dental coverage established by the Plan Sponsor for eligible persons pursuant to this Handbook.

Delta Dental of New Mexico

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Albuquerque, NM 87110
(505) 855-7111
(877) 395-9420
www.deltadentalnm.com

DELTA DENTAL

Delta Dental PPO^{SM} Point of Service
Summary of Dental Plan Benefits
For Group #8524
County of Los Alamos

Benefit Period: January 1 through December 31

Deductible: $50 Deductible per person total per Benefit Period limited to a maximum Deductible of $150 per family per Benefit Period

Maximum Benefit Amount: $1,500 per person total per Benefit Period

Orthodontic Lifetime Maximum: $1,000 per person total per lifetime

Covered Services	Delta Dental PPO^{SM} Provider	Delta Dental Premier® Provider	Non-Participating Provider*
	You Pay	You Pay	You Pay*
Diagnostic and Preventive Services			
Diagnostic and Preventive Services – exams, cleanings, topical fluoride, and space maintainers	No Charge	No Charge	No Charge
Emergency Palliative Treatment – to temporarily relieve pain	No Charge	No Charge	No Charge
Sealants – to prevent decay of permanent teeth	No Charge	No Charge	No Charge
Brush Biopsy – to detect oral cancer	No Charge	No Charge	No Charge
Radiographs – images	No Charge	No Charge	No Charge
Periodontal Maintenance – cleanings following periodontal therapy	No Charge	No Charge	No Charge
Basic Services			
Minor Restorative Services – fillings	20%	20%	20%
Endodontic Services – root canals	20%	20%	20%
Periodontic Services – to treat gum disease	20%	20%	20%
Oral Surgery Services – extractions and dental surgery	20%	20%	20%
Other Basic Services – misc. services	20%	20%	20%
Major Services			
Crown Repair – to individual crowns	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	50%	50%	50%
Prosthodontic Services – bridges, dentures, and implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%, up to Lifetime Maximum	50%, up to Lifetime Maximum	50%, up to Lifetime Maximum
Orthodontic Age Limit- child and adult	No Age Limit	No Age Limit	No Age Limit

**Selecting a Non-Participating Provider may result in higher out-of-pocket expenses, even when there is no change in Benefit level between in-network and out-of-network Benefits. Non-Participating Providers do not accept Delta Dental's Maximum Approved Fees as payment in full. You will be financially responsible for balance billed amounts, or amounts that exceed the Non-Participating Provider's reimbursement. See the section titled "Your Network."*

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Routine prophylaxes (cleanings), periodontal maintenance, and scaling in the presence of generalized moderate or severe gingival inflammation are payable twice per calendar year.
- Topical fluoride treatments are payable twice per calendar year for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 14.
- Bitewing images are payable twice per calendar year and a complete series of radiographic images (which include bitewing images) or panoramic radiographic image is payable once in any five-year period.
- Sealants are payable once per tooth per three-year period for the occlusal surface of permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are covered services on all teeth.
- Implants and implant-related services are payable once per tooth in any five-year period.

Additional Plan Information

Deductible: Does not apply to Diagnostic and Preventive Services, radiographic images, sealants, full mouth debridement, periodontal maintenance, emergency palliative treatment, consultations, cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Maximum Benefit Amount: The Maximum Benefit Amount applies to all services except cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Orthodontic Lifetime Maximum: Applies to cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Pre-Treatment Estimates: Delta Dental recommends that you ask your Provider for a Pre-Treatment Estimate when more-costly procedures are anticipated. This free report estimates your applicable dental Benefits and out-of-pocket expenses for proposed dental services. Please see the Dental Benefit Handbook for more information. Pre-Treatment Estimates are optional unless specified otherwise in this Summary of Dental Plan Benefits.

Eligibility Provisions

An Eligible Employee is an employee who satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Group and agreed to by Delta Dental. Waiting period shall not exceed twelve (12) months.

Eligible Employees may enroll on the first day of the month following their date of hire, subject to any additional requirements which may apply.

Benefits will cease on the last day of the month in which the employee is terminated, subject to any

Domestic Partners are not eligible to enroll in this Plan.

Special Benefit Provisions

None.

Your Network: Delta Dental PPO Point of Service

This section describes the types of Providers you may visit under your Plan and how fees and payments will work for different Providers.

Delta Dental PPO Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Lowest
Delta Dental Pays Up To:	Delta Dental PPO Maximum Approved Fees
Provider May Balance Bill You?	No
Description	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

Delta Dental Premier Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Higher than Delta Dental PPO
Delta Dental Pays Up To:	Delta Dental Premier Maximum Approved Fees
Provider May Balance Bill You?	No
Description	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental Premier Maximum Approved Fees. You are also responsible for the full payment for any non-covered services. Coinsurance amounts may be higher when selecting a Delta Dental Premier Provider.

Non-Participating Provider	
Participates with Delta Dental?	No
Out-of-Pocket Costs for This Plan:	Highest
Delta Dental Pays Up To:	Delta Dental's Non-Participating Maximum Approved Fees
Provider May Balance Bill You?	Yes, up to the Provider's Submitted Amount
Description	In addition to any Coinsurance, Deductible (if applicable), and fees for non-covered services, you will be responsible for any difference between Delta Dental's Non-Participating Maximum Approved Fees and the Provider's Submitted Amount. Subscribers are responsible for full payment to a Non-Participating Provider. Any payment made by Delta Dental for services received from a Non-Participating Provider may be paid to the Provider or directly to the Subscriber.

Understanding Your Benefits

This Summary of Dental Plan Benefits has been prepared only for Open Enrollment purposes.

This Summary of Dental Plan Benefits only highlights Benefit levels; it does not provide complete coverage information. Refer to your Dental Benefit Handbook for other important eligibility and Plan provisions. This Summary of Dental Plan Benefits is attached to and is a component of the Dental Benefit Handbook. To the extent that the rules in the Dental Benefit Handbook conflict with the ones stated in this Summary of Dental Plan Benefits, the rules in this Summary of Dental Plan Benefits control.

Call Delta Dental's Customer Service Department at (877) 395-9420, or log into the Consumer Toolkit via www.deltadentalnm.com, for answers to questions about Benefits and claims.

Business Associate Agreement

RFP Name: Dental Insurance Benefits for Los Alamos County Employees

BUSINESS ASSOCIATES AGREEMENT

This Agreement ("Agreement") is made and entered into on this **1st day** of **January 2020,** by and between Delta Dental of New Mexico("Business Associate"), and **INCORPORATED COUNTY OF LOS ALAMOS,** an incorporated county of the State of New Mexico ("Covered Entity").

WHEREAS, Business Associate acknowledges that Covered Entity has in its possession data that contains individual identifiable health information as defined by Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA") and the regulations promulgated thereunder; and

WHEREAS, Business Associate and Covered Entity are parties to an agreement (the "Service Agreement"), pursuant to which the fulfillment of the Parties' obligations thereunder necessitates the exchange of, or access to, data including individual identifiable health information,

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter contained, the Parties agree as follows:

ARTICLE 1
DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the meanings set forth below.

1.1 "HHS" shall mean the U.S. Department of Health and Human Services.

1.2 "HHS Transaction Standard Regulation" means the Code of Federal Regulations ("CFR") at Title 45, Sections 160 and 162.

1.3 "Individual" means the subject of protected health information or, if deceased, his or her personal representative.

1.4 "Parties" shall mean the Covered Entity and Business Associate. (Covered Entity and Business Associate, individually, may be referred to as a "Party.")

1.5 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

1.6 "PHI" shall have the same meaning as the term "protected health information" found in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of the Covered Entity.

1.7 "Required by law" shall have the same meaning as "required by law" in 45 CFR §164.501.

1.8 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

ARTICLE 2
CONFIDENTIALITY

2.1 Obligations and Activities of Business Associate. Business Associate agrees as follows:

(a) not to use or further disclose PHI other than as permitted or required by this Agreement or as Required By Law;
(b) to establish, maintain, and use appropriate safeguards to prevent use or disclosure of the PHI other than as permitted herein;
(c) to report to Covered Entity any use, access or disclosure of the PHI not provided for by this Agreement, or any misuse of the PHI, including but not limited to systems compromises of which it becomes aware and to mitigate, to the extent practicable, any harmful effect that is known to Business Associate as a result thereof;
(d) to enforce and maintain appropriate policies, procedures, and access control mechanisms to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. The access and privileges granted to any such agent shall be the minimum necessary to perform the assigned functions;
(e) to provide access, at the request of Covered Entity, and in the time and manner reasonable designated by Covered Entity, to PHI in a Designated Record Set (as defined in the Privacy Rule), to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR §164.524;
(f) to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the request of Covered Entity or an Individual, and in the time and manner reasonably requested by Covered Entity.
(g) to make, enact, and maintain internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner reasonably requested by Covered Entity or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule;
(h) to document such disclosures of PHI, and information related to such disclosures, as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528;
(i) to provide to Covered Entity or an Individual, in a time and manner reasonably requested by Covered Entity, information collected in accordance with Section 2.1(i) above to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528;
(j) to promptly notify Covered Entity of all actual or suspected instances of deliberate unauthorized attempts (both successful and unsuccessful) to access PHI;
(k) to maintain and enforce policies, procedures and processes to protect physical access to hardware, software and/or media containing PHI (e.g., hardcopy, tapes, removable media, etc.) against unauthorized physical access during use, storage, transportation, disposition and /or destruction; and
(l) to ensure that access controls in place to protect PHI and processing resources from unauthorized access are controlled by two-factor identification and authentication: a user ID and a Token, Password or Biometrics.

2.2 Disclosures Required By Law.

In the event that Business Associate is required by law to disclose PHI, Business Associate will immediately provide Covered Entity with written notice and provide Covered Entity an opportunity to oppose any request for such PHI or to take whatever action Covered Entity deems appropriate.

2.3 Specific Use and Disclosure Provisions.

(a) Except as otherwise limited in this Agreement, Business Associate may use PHI only to carry out the legal responsibilities of the Business Associate under the Service Agreement.

(b) Except as otherwise limited in this Agreement, Business Associate may only disclose PHI (i) as Required By Law, or (ii) in the fulfillment of its obligations under the Service Agreement and provided that Business Associate has first obtained (A) the consent of Covered Entity for such disclosure, (B) reasonable assurances from the person to whom the information is disclosed that the PHI will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, (C) reasonable assurances from the person to whom the information is disclosed that such person will notify the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached, and (D) "except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

2.4 Obligations of Covered Entity.

(a) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

(b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosures of PHI.

(c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(d) For any PHI received by Covered Entity from Business Associate on behalf of a third party or another covered entity, Covered Entity agrees to be bound to the obligations and activities of Business Associate enumerated in Section 2.1 as if and to the same extent Covered Entity was the named Business Associate hereunder.

2.5 Permissible Requests by Covered Entity.

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Covered Entity.

2.6 Policy and Procedure Review.

Upon request, Business Associate shall make available to Covered Entity any and all documentation relevant to the safeguarding of PHI including but not limited to current policies and procedures, operational manuals and/or instructions, and/or employment and/or third party agreements.

ARTICLE 3
SECURITY

3.1 Government Healthcare Program Representations.

Business Associate hereby represents and warrants to Covered Entity, its members, directors, officers, agents, representatives, or employees that Business Associate has not been excluded or has not been served a notice of exclusion or has not been served with a notice of proposed exclusion, or has not committed any acts which are cause for exclusion, from participation in, or had any sanctions, or civil or criminal penalties imposed under, any federal or state healthcare program, including but not limited to Medicare or Medicaid, and has not

been convicted, under federal or state law (including without limitation a plea of nolo contendere or participation in a first offender deterred adjudication or other arrangement whereby a judgment of conviction has been withheld), of a criminal offense related to (a) the neglect or abuse of a patient, (b) the delivery of an item or service, including the performance of management or administrative services related to the delivery of an item or service, under a federal or state healthcare program, (c) fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a healthcare item or service or with respect to any act or omission in any program operated by or financed in whole or in party by any federal, state or local government agency, (d) the unlawful, manufacture, distribution, prescription, or dispensing of a controlled substance, or (e) interference with or obstruction of any investigation into any criminal offense described in (a) through (d) above. Business Associate further agrees to notify Covered Entity immediately after Business Associate becomes aware that the foregoing representation and warranty may be inaccurate or may be incorrect.

3.2 Security Procedures.

Each Party shall employ security procedures that comply with HIPAA and all other applicable state and federal laws and regulations (collectively, the "Law") and that are commercially reasonable, to ensure that transactions, notices, and other information that are electronically created, communicated, processed, stored, retained or retrieved are authentic, accurate, reliable, complete and confidential. Moreover, each Party shall, and shall require any agent or subcontractor involved in the electronic exchange of data to:

(a) require its agents and subcontractors to provide security for all data that is electronically exchanged between Covered Entity and Business Associate;
(b) provide, utilize, and maintain equipment, software, services and testing necessary to assure the secure and reliable transmission and receipt of data containing PHI;
(c) maintain and enforce security management policies and procedures and utilize mechanisms and processes to prevent, detect, record, analyze, contain and resolve unauthorized access attempts to PHI or processing resources;
(d) maintain and enforce polices and guidelines for workstation use that delineate appropriate use of workstations to maximize the security of data containing PHI;
(e) maintain and enforce policies, procedures and a formal program for periodically reviewing its processing infrastructure for potential security vulnerabilities; and
(f) implement and maintain, and require its agents and subcontractors to implement and maintain, appropriate and effective administrative, technical and physical safeguards to protect the security, integrity and confidentiality of data electronically exchanged between Business Associate and Covered Entity, including access to data as provided herein. Each Party and its agents and subcontractors shall keep all security measures current and shall document its security measures implemented in written policies, procedures or guidelines, which it will provide to the other Party upon the other Party's request.

ARTICLE 4
EXCHANGE OF STANDARD TRANSMISSIONS

4.1 Obligations of the Parties. Each of the Parties agrees that for the PHI:

(a) it will not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation.

(b) it will not add any data elements or segments to the maximum denied data set as proscribed in the HHS Transaction Standard Regulation.

(c) it will not use any code or data elements that are either marked "not used" in the HHS Standard's implementation specifications or are not in the HHS Transaction Standard's implementation specifications.

(d) it will not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications.

4.2 Incorporation of Modifications to HHS Transaction Standards.

Each of the Parties agrees and understands that from time-to-time, HHS may modify and set compliance dates for the HHS Transaction Standards. Each of the Parties agrees to incorporate by reference into this Agreement any such modifications or changes.

4.3 Business Associate Obligations.

(a) Business Associate shall not submit duplicate transmissions unless so requested by Covered Entity.

(b) Business Associate shall only perform those transactions, which are authorized by Covered Entity. Furthermore, Business Associate assumes all liability for any damage, whether direct or indirect, to the electronic data or to Covered Entity's systems caused by Business Associate's unauthorized use of such transactions.

(c) Business Associate shall hold Covered Entity harmless from any claim, loss or damage of any kind, whether direct or indirect, whether to person or property, arising out of or related to (1) Business Associate's use or unauthorized disclosure of the electronic data; or (2) Business Associate's submission of data, including but not limited to the submission of incorrect, misleading, incomplete or fraudulent data and agrees to indemnify Covered Entity for any damages, costs, expenses or liabilities, including legal fees and costs, arising from or related to a breach of the Business Associate's obligations hereunder.

(d) Business Associate agrees to maintain adequate back-up files to recreate transmissions in the event that such recreations become necessary. Back-up devices shall be subject to this Agreement to the same extent as original data.

(e) Business Associate agrees to trace lost or indecipherable transmissions and make reasonable efforts to locate and translate the same. Business Associate shall bear all costs associated with the recreation of incomplete, lost or indecipherable transmissions if such loss is the result of an act or omission of Business Associate.

(f) Business Associate shall maintain, for seven (7) years, true copies of any source documents from which it produces electronic data.

(g) Except encounter data furnished by Business Associate to Covered Entity, Business Associate shall not (other than to correct errors) modify any data to which it is granted access under this Agreement or derive new data from such existing data. Any modification of data is to be recorded, and a record of such modification is to be retained by Business Associate for a period of seven (7) years.

(h) Business Associate shall not disclose security access codes to any third party in any manner without the express written consent of Covered Entity. Business Associate furthermore acknowledges that Covered Entity may change such codes at any time without notice. Business Associate shall assume responsibility for any damages arising from its disclosure of the security access codes or its failure to prevent any third party use of the system without the express written consent of Covered Entity.

(i) Business Associate shall maintain general liability coverage, including coverage for general commercial liability, for a limit of not less than one million dollars, as well as other coverage as Covered Entity may require, to compensate any parties damaged by Business Associate's negligence. Business Associate shall provide evidence of such coverage in the form of a

certificate of insurance and agrees to notify Covered Entity and/or HOI immediately of any reduction or cancellation of such coverage.

(j) Business Associate agrees to conduct testing with Covered Entity to ensure delivery of files that are HIPAA-AS Compliant and to accommodate Covered Entity specific business requirements.

4.4 Confidential and Proprietary Information.

(a) Proprietary Information

Business Associate acknowledges that it will have access to certain proprietary information used in Covered Entity's business. Covered Entity's proprietary information derives its value from the fact that it is not available to competitors or any third parties, and the disclosure of this information would or could impair Covered Entity's competitive position or otherwise prejudice its ongoing business. Business Associate agrees to treat as confidential, and shall not use for its own commercial purpose or any other purpose, Covered Entity's proprietary information. Business Associate shall safeguard Covered Entity's proprietary information against disclosure except as may be expressly permitted herein. Such proprietary information includes, but is not limited to, confidential information concerning the business operations or practices of Covered Entity, including specific technology processes or capabilities.

ARTICLE 5
MISCELLANEOUS

5.1 Term and Termination.

(a) Term. The Term of this Agreement shall be effective as of the date first written above, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) Termination for Cause. Upon a material breach by Business Associate of it obligation hereunder, Covered Entity may (i) terminate this Agreement and the Service Agreement; and (ii) report the violation to the Secretary.

(c) Effect of Termination.

(i) Except as provided in paragraph 5.1(c)(ii), upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(ii) In the event that Business Associate determines that returning the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

5.2 Disputes.

In any lawsuit or legal dispute arising from the operation of this Agreement, Business Associate agrees that the laws of the State of New Mexico shall govern. Venue shall be in the First Judicial District Court of New Mexico in Los Alamos County, New Mexico.

5.3 Injunctive Relief.

Notwithstanding any rights or remedies provided for in Section 5.2, Covered Entity retains all rights to seek injunctive relief to prevent the unauthorized use of disclosure of PHI by Business Associate or any agent, contractor or third party that received PHI from Business Associate.

5.4 Regulatory References.

A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

5.5 Amendment.

The Parties agree to take such action as is necessary to amend this Agreement from time to time to the extent necessary for Covered Entity to comply with the requirements of HIPAA and its regulations. All amendments to this agreement shall be in writing and signed by both parties.

5.6 Survival.

The respective rights and obligations of Business Associate and Covered Entity under Sections 4.4, and 5.1(c) of this Agreement shall survive the termination of this Agreement.

5.7 Interpretation.

Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year below written.

Business Associate:	**Covered Entity:**
By: /s/ Lou J. Ottino	By: _____
Title: VP of Sales and Marketing	Title: _____
Date: July 23, 2019	Date: _____