**RESOLUTION NO. R16-41**

**A RESOLUTION OF THE CITY COUNCIL AUTHORIZING THE MAYOR TO SIGN RENEWAL AGREEMENTS WITH BLUE CROSS BLUE SHIELD OF MONTANA, DELTA DENTAL AND VSP FOR THE PROVISION OF THE EMPLOYEE HEALTH INSURANCE PROGRAM.**

WHEREAS, the City Council approved agreements with Blue Cross Blue Shield of Montana, Delta Dental and VSP ("Insurers") for the City employee health insurance program through Resolution No. R15-59 on June 16, 2015; and

WHEREAS, the Insurers have provided the City with their respective yearly renewal agreements for the City's review and consideration; and

WHEREAS, City staff reviewed the agreements and determined renewal of the same is in the best interests of the City and its employees.

NOW THEREFORE BE IT RESOLVED by the City Council of the City of Laurel, Montana, that the Mayor is authorized to sign renewal agreements with Blue Cross Blue Shield of Montana, Delta Dental and VSP for the employee health insurance program, copies of which are attached hereto.

Introduced at a regular meeting of the City Council on June 7, 2016, by Council Member Herr.

PASSED and ADOPTED by the City Council of the City of Laurel, Montana, this 7th day of June, 2016.

APPROVED by the Mayor this 7th day of June, 2016.

CITY OF LAUREL

Mark A. Mace, Mayor

ATTEST:

Shirley Ewan, Clerk/Treasurer

Approved as to form:

Sam S. Painter, Civil City Attorney

BlueCross BlueShield of Montana

560 N. Park Avenue
PO Box 4309
Helena, Montana 59604
Customer Information Line: 800.447.7828

**www.bcbsmt.com**

July 1, 2016

NEVA HALL
CITY OF LAUREL ($1,000)
PO BOX 10
LAUREL MT 59044-

Group Name: CITY OF LAUREL ($1,000)
Group No: 138674
Effective Date: July 1, 2016

The Group Contract(s) and Member Guides for the above-named group have been prepared in accordance with the enclosed Group Application. The enclosed rates will be effective as of the effective date noted above.

The Group Contract(s), Member Guides and notices will be mailed to you separately from our distribution center. Please distribute the Member Guides and notices to your covered employees. Additional Member Guides will be included so that you have a supply on hand for any new employee who enrolls in the health plan during the year. You may also request additional Member Guides, if necessary, by contacting Customer Service at 1-800-447-7828.

Contracts and Member Guides are available on-line on Blue Access for Employers℠ (BAE) and Member Guides on Blue Access for Members℠ (BAM).

If you have questions, please contact a Service Team Representative at 1-800-447-7828.

We are pleased to continue serving you.

Enclosures

BlueCross BlueShield of Montana

# LARGE GROUP APPLICATION ("Application")
**Blue Cross and Blue Shield of Montana ("BCBSMT")**
101 OR MORE ELIGIBLE EMPLOYEES

Account Status: Existing with Changes

Employer Account Number (6-digits): 138674 Group Number(s): 138706 Section Number(s): 0003,0004,0005,9903,0006,0007, 0008,9904

Contract Effective Date: 07/01/2016 Contract Anniversary Date (AD): 07/01/2017

Legal Employer Name: **City of Laurel**
(Specify the employer or the employee trust applying for coverage. An employee benefit plan *may not* be named.)

**ERISA Regulated Group Health* Plan:** ☐ Yes ☒ No

If Yes, is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified above? ☐Yes ☐No
If No, please specify your ERISA Plan Year (month/day/year): Beginning Date __/__/__ End Date __/__/__

ERISA Plan Administrator*: _____ ERISA Plan Address: _____

If you maintain that ERISA is not applicable to your group health plan, please give legal reason for exemption:
☐ Federal Governmental plan (e.g., the government of the United States or agency of the United States)
☒ Non-Federal Governmental plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
☐ Church plan
☐ Other; please specify: _____

Is your Non-ERISA Plan Year a period of 12 months beginning on the Anniversary Date specified above? ☒Yes ☐No
If No, please specify your Non-ERISA Plan Year (month/day/year): Beginning Date __/__/__ End Date __/__/__

**For more information regarding ERISA, contact your legal advisor.**

*All as defined by ERISA and/or other applicable law/regulations

## ACCOUNT INFORMATION

☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Employer Identification Number: 81-6001283 SIC: 9910 Nature of Business: City Government

Primary Address: P.O. Box 10

City: Laurel State: MT Zip: 59044

Administrative Contact: Neva Hall Title: Clerk

Phone: (406) 628-7431 ext 4 Fax: (406) 628-2289 Email: nhall@laurel.mt.gov

Physical Address (if different from Primary): 115 West 1st Street

City: Laurel State: MT Zip: 59044

Administrative Contact: Neva Hall Title: Clerk

Phone: (406) 628-7431 ext 4 Fax: (406) 628-289 Email: nhall@laurel.mt.gov

Billing Address (if different from Primary):

City: State: Zip:

Billing Contact: Neva Hall Title: Clerk

Phone: (406) 628-7431 ext 4 Fax: (406) 628-2289 Email: nhall@laurel.mt.gov

Blue Access for Employers (BAE) Contact: Neva Hall Title: Clerk
(The BAE Contact is an Employee who is authorized by the Employer to access and maintain the account in BAE.)

Phone: (406) 628-7431 ext 4 Fax: (406) 628-2289 Email: nhall@laurel.mt.gov

Subsidiary/Affiliated Company:
If necessary, list additional subsidiary companies and subsidiary company addresses in the Additional Provisions section.

Contact: Title:

Subsidiary/Affiliated Companies Address:

City: State: Zip:

## PRODUCER OF RECORD INFORMATION

☒ NO CHANGES

1.*Producer/Agency** name to whom commissions are to be paid: David Allen

Producer Number of ☒ Producer or ☐ Agency: 046274000

Street Address: 2048 Overland Ave. City: Billings State: MT Zip: 59102

Phone: (406) 656-2324 Fax: (406) 294-0276 Email: dave@davealleninsurance.com

Is Producer/Agency appointed with BCBSMT? ☒ Yes ☐ No

**If commissions apply, check all active lines of business, list the commission rate and select the calculation method.**

| Line of Business | Commission Rate | Calculation Method |
|---|---|---|
| ☒ Health | 1.32% | % Premium |
| ☐ Dental | | Select from dropdown |

2. *Producer/Agency** name to whom commissions are to be paid: _____

Producer Number of ☐ Producer or ☐ Agency: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Is Producer/Agency appointed with BCBSMT? ☐ Yes ☐ No

If commission split, designate percentage for each Producer/Agency. **Note**: total commissions paid must equal 100%.

Producer/Agency 1: _____% Producer/Agency 2: _____%

If applicable, effective _____, the named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR), to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Montana, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for employer's employee benefit programs. This statement rescinds any and all previous POR appointments for employer. The POR is authorized to perform membership transactions on behalf of employer. This appointment will remain in effect until withdrawn or superseded in writing by employer.

*The producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

** If commissions are split, please provide the information requested above on both producers/agencies. BOTH must be appointed to do business with BCBSMT.

## SCHEDULE OF ELIGIBILITY

☐ **NO CHANGES**

1. **Employee Eligibility Provisions:** All employees working a minimum of 20 hours per week.
   **Specify:**
   ☒ Full-time employee of the employer.
   ☒ Part-time employee of the employer.
   ☒ COBRA
   ☒ Retiree of the employer. Define criteria: Public Employee Retiree Criteria (PERS)
   ☐ Other: _____
   Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No
   If Yes, please identify the classes and describe the exclusion: _____

2. **Are Spouses eligible for coverage:** ☒ Yes ☐ No

3. **Are Domestic Partners eligible for coverage:** (If coverage for a spouse is not available, coverage for a Domestic Partner is not available.) ☒ Yes ☐ No (skip to question 4)
   A Domestic Partner means a person with whom the employee has entered into a domestic partnership in accordance with the employer's plan guidelines. The employer is responsible for providing notice of possible tax implications to those covered employees with Domestic Partners.
   Are Domestic Partners eligible for continued coverage equivalent to COBRA continuation? ☒ Yes ☐ No

4. **Probationary Waiting Period:** All current and new Employees must satisfy the substantive eligibility criteria and required waiting period in order for coverage to become effective. Covered eligible Dependents do not have to satisfy a probationary waiting period to become effective, but in no instance shall an eligible Dependent be covered prior to the Employee's effective date.

   The effective date of coverage for a newly Eligible Employee is: (Note: No probationary waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an individual becomes eligible for coverage):
   ☐ The date of employment (date of hire).
   ☐ The _____ day (standard is 1st or 15th) of the month following the date of employment
   ☐ The _____ day (standard is 1st or 15th) of the month following _____ days (select 0, 30 or 60 days) of employment.
   ☐ The _____ day (standard is 1st or 15th) of the month following _____ month(s) (select 1 or 2 months) of employment.
   ☒ The 1st of the month following date of hire: unless date of hire falls on the 1st -then eligible to enroll date of hire.

   day of employment (select any number of days less than or equal to 91; examples - 10th, 14th, or 21st day of employment).

   **Substantive Eligibility Criteria:** Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, you are required to submit a new BPA to reflect that new information.

   Check all that apply:

   ☐ An Orientation Period that:

   1) Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
   2) If used in conjunction with a waiting period the waiting period begins on the first day after the orientation period.

   ☐ A Cumulative hours of service requirement that does not exceed 1200 hours

   ☐ An hours of service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:

   1) Starts between the employee's date of hire and the first day of the following month;
   2) Does not exceed 12 months; and

3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

☐ Other substantive eligibility criteria not described above; please describe:

_____

_____

_____

5. **Are there multiple new hire probationary waiting periods?** ☐ Yes ☒ No
(Note: No combined probationary waiting periods may result in an effective date that exceeds ninety-one (91) calendar days from the date that an individual becomes eligible for coverage.)

If Yes, attach eligibility and contribution details for each section.
New Groups Only - Is the probationary waiting period requirement to be waived on initial group enrollment?
Health: ☐ Yes ☐ No ☐ N/A Dental: ☐ Yes ☐ No ☐ N/A

6. **The date of termination for a person who ceases to meet the definition of Eligible Person will be:**

**1st of the month group renewal and billing date**
- ☒ Last day of the month in which the covered person(s) is (are) no longer eligible.
- ☐ Other (please specify): _____

**15th of the month group renewal and billing date**
- ☐ 14th of the month in which the covered person(s) Is (are) no longer eligible
- ☐ Other (please specify): _____

7. **The minimum standard limiting age for covered Dependent children is twenty-six (26) years.** Dependent children under age 26 are eligible for coverage until their 26th birthday. Dependent child, used hereafter, means a natural child, a stepchild, an eligible foster child, an adopted child or child placed for adoption (including a child for whom the Member or his/her spouse is a party in a legal action in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally dependent upon the Member or spouse is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application.

A Dependent child who is medically certified as intellectually disabled or physically disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

8. Blue Directions (Private Exchange) purchased ☐ Yes ☒ No

## CURRENT ELIGIBILITY INFORMATION

☐ **NO CHANGES**

**Total number of Employees/Subscribers:**

1. On payroll 63
2. On COBRA continuation coverage 1
3. With retiree coverage (if applicable) 2
4. Who work part-time 7
5. Serving the new hire probationary waiting period 2
6. Declining because of other group coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) NA
7. Declining coverage (not covered elsewhere) NA

☐ NO CHANGES

## LINES OF BUSINESS
**(Check all applicable products)**

All benefits will be processed according to State and Federal mandates.

| | Deductible (Individual/Family) | Coinsurance (In-network/Out-of-network) | Out-of-Pocket (Individual/Family) | Office Visit Copay (if applicable) |
|---|---|---|---|---|
| ☒ Blue Dimensions (PPO) | | | | |
| Plan: 80/20 | $1,000 / $2,000 | 80/20%/65/35% | $2,500 / $5,000 | $25 |
| Plan: 70/30 | $1,500 / $3,000 | 70/30%/55/45% | $3,500 / $7,000 | $35 |
| ☐ Blue Edge HSA Plus ☐ PPO ☐ Traditional (Embedded Deductible) | | | | |
| Plan: | $ / $ | % / % | $ / $ | $ |
| Plan: | $ / $ | % / % | $ / $ | $ |
| ☐ Blue Edge HSA Standard ☐ PPO ☐ Traditional | | | | |
| Plan: | $ / $ | % / % | $ / $ | $ |
| Plan: | $ / $ | % / % | $ / $ | $ |
| ☐ Comprehensive Major Medical ☐ PPO ☐ Traditional | | | | |
| Plan: | $ / $ | % / % | $ / $ | $ |
| Plan: | $ / $ | % / % | $ / $ | $ |
| ☐ Health First ☐ PPO ☐ Traditional | | | | |
| Plan: | $ / $ | % / % | $ / $ | $ |
| Plan: | $ / $ | % / % | $ / $ | $ |
| ☐ BlueEdge HCA (PPO) | | | | |
| Plan: | $ / $ | % / % | $ / $ | $ |
| Plan: | $ / $ | % / % | $ / $ | $ |

| | Deductible (In-Network/Out-of-Network) | Coinsurance (In-network/Out-of-network) | Out-of-Pocket (In-Network/Out-of-Network) | Office Visit Copay PCP/SPC (if applicable) |
|---|---|---|---|---|
| ☐ Blue Choice (HSA) (PPO) | | | | |
| Marketing ID Number: | $ / $ | $ / $ | $ / $ | $ |
| Marketing ID Number: | $ / $ | $ / $ | $ / $ | $ |
| ☐ Blue Choice (PPO) | | | | |
| Marketing ID Number: | $ / $ | $ / $ | $ / $ | $ / $ |
| Marketing ID Number: | $ / $ | $ / $ | $ / $ | $ / $ |

**Health Care Management Services**

☐ **Total Health Management (THM)** (additional charges apply)

☐ **Employee Assistance Program (EAP)**

**Dental Coverage**
☐ Yes If Yes, please list plan:
☒ No

**Vision Coverage**
☐ Yes, Standard Coverage
☐ Yes, Custom Coverage
☒ No

☐ **Life & Disability** (if checked, attach separate Dearborn National application)

☒ **HCSC COBRA Administrative Services** - If selected, complete separate COBRA Administrative Services Addendum. If not selected, please provide name of entity administering COBRA: _____

**COMMENTS:** Group is renewing with Benefit Changes to Dual Option Blue Dimensions Plans:
80/20 Plan Changes: Deductible $1,000 Ind/$2,000 Family; OOP $2,500 Ind./$5,000 Family; RX deductible $100; co-ins; OVC staying the same;

70/30 Plan Changes: Deductible $1,500 Ind/$3,000 Family; OOP $3,500/$7,000 Family; RX deductible $100; Co-ins; OVC staying the same.
Out-of-Network Preventive benefits added at renewal: OON Preventive applies to deductible and oon co-ins; OON Well Child services waives deductible/applies to oon co-ins; OON routine Mammograms $70 paid then applies to deductible/oon co-ins; OON medical mammograms apply to deductible/oon co-ins
Group does not utilize Substantive Eligiblity Criteria.
Additional Authorized Contacts: City Clerk Shirley Ewan; Kelly Strecker

## ACCOUNT EXPERIENCE – NEW GROUPS ONLY

Has there been a significant change in the claims experience previously provided?

☐ No – skip the rest of this (Account Experience) section

☐ Yes – Please answer the below questions to the best of your knowledge. Note: any changes indicated below may impact rates and will require Underwriter approval. "Member" means all Eligible Employees, Dependent children, Retirees and COBRA Continuants.

1. Has any Member received more than $20,000 in medical benefits during the last 12 months? ☐ Yes ☐ No
2. Is any Member expected to have claims in excess of $20,000 during the next 12 months? ☐ Yes ☐ No
3. Is any Member mentally or physically handicapped or disabled or not actively at work? ☐ Yes ☐ No
4. Has any Member been diagnosed as having a high risk condition? ☐ Yes ☐ No

If any question is answered "yes," details must be provided below:

| Member Age | Diagnosis or Nature of the Disorder | Dates of Treatment | $ Amount of Claims | Prognosis/Current Treatment |
|---|---|---|---|---|
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |

## RATES

For the current year's premium rate information, refer to the accepted finalized new group/renewal Option Sheet for complete details. The Option Sheet shall be incorporated by reference and made part of the Application and Group Contract.

## SPECIAL FINANCIAL ARRANGEMENT

☒ NO CHANGES

Special financial arrangement: ☐ Yes ☒ No If yes, provide additional information below

| | Definition of terms (e.g. 50/50) | |
|---|---|---|
| ☐ Minimum Premium | | Retention Factor: _____ |
| ☐ Modified Retention | | Retention Factor: _____ |
| ☐ Full Retention | | Retention Factor: _____ |
| ☐ Contingent Premium | | |
| ☐ Other | | |

☐ Aggregate Stop-Loss ☐ Yes ☐ No Attachment Point _____% of expected claims

☐ Specific Stop-Loss ☐ Yes ☐ No Terms (i.e. attachment point and monthly or annual accommodation): _____

☐ Premium Deferral ☐ Yes ☐ No If Yes, please specify months _____

Options: 100-199 Contracts = 2 Months
200+ Contracts = 3 Months

**Additional Information:**

## STANDARD PREMIUM INFORMATION

1. **Premium Period:**
   - ☒ The first day of each calendar month through the last day of each calendar month.
   - ☐ The 15th day of each calendar month through the 14th day of the next calendar month.
   - ☐ 15/16 Day Rule – premiums will be billed for the entire month for Members with effective dates on the 1st through the 15th day of the month. Premiums will not be billed for the month when the Member's effective date falls on the 16th day through the end of the month.

2. **Contribution of premium to be paid by the employer.**

| PRODUCT | Employee | Eligible Dependents |
|---|---|---|
| **HEALTH** | | |
| Plan 1 Blue Dimensions 80/20 | % or $767.87 | Varies% or $ |
| Plan 2 Blue Dimensions 70/30 | % or $ 767.87 | Varies % or $ |
| Plan 3 | % or $ | % or $ |
| **DENTAL** | | |
| Plan 1 | % or $ | % or $ |

BCBSMT reserves the right to take any or all of the following actions:

a) initial rates for new groups will be finalized for the effective date of the contract based on the enrolled participation and employer contribution levels; b) after the policy effective date, the group will be required to maintain a minimum employer contribution of 50%, and at least a 75% participation of eligible employees. In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or c) non-renew or discontinue coverage unless the 50% minimum employer contribution is met and at least 75% of eligible employees have enrolled for coverage.

BCBSMT reserves the right to change premium rates when a substantial change occurs in the number or composition of members covered. A substantial change will be deemed to have occurred when the number of Employees/Members covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

Employer will promptly notify BCBSMT of any change in participation and Employer contribution.

$784.69

**Additional Information/Comments**: City of Laurel provides a flat $ contribution as follows: - Employee: ~~$767.87~~ Emp/Children: ~~$767.87~~; $1,100 - Employee/Spouse; $1,100 - Family.

$784.69

## BILLING SPECIFICATIONS

☒ **NO CHANGES**

The information provided within this section will be used to establish the format of your billing statement(s).

**Member list sorted by:** ☒ Unique Identification Number (standard) ☐ Social Security Number

**Please provide a detailed description of the preferred billing format** (for example: Billing statement to be broken out by Department, Location, Class): Active, Retirees Under 65; Retirees Over 65; COBRA

## ID CARD DELIVERY

☒ **NO CHANGES**

Mail ID Cards to:

- ☒ Member's home (standard)
- ☐ Account

## STANDARD PREMIUM INFORMATION

1. **Premium Period:**
   - ☒ The first day of each calendar month through the last day of each calendar month.
   - ☐ The 15th day of each calendar month through the 14th day of the next calendar month.
   - ☐ 15/16 Day Rule – premiums will be billed for the entire month for Members with effective dates on the 1st through the 15th day of the month. Premiums will not be billed for the month when the Member's effective date falls on the 16th day through the end of the month.

2. **Contribution of premium to be paid by the employer.**

| PRODUCT | Employee | Eligible Dependents |
|---|---|---|
| **HEALTH** | | |
| Plan 1 Blue Dimensions 80/20 | % or $784.69 | Varies% or $ |
| Plan 2 Blue Dimensions 70/30 | % or $ 784.69 | Varies % or $ |
| Plan 3 | % or $ | % or $ |
| **DENTAL** | | |
| Plan 1 | % or $ | % or $ |

BCBSMT reserves the right to take any or all of the following actions:

a) initial rates for new groups will be finalized for the effective date of the contract based on the enrolled participation and employer contribution levels; b) after the policy effective date, the group will be required to maintain a minimum employer contribution of 50%, and at least a 75% participation of eligible employees. In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or c) non-renew or discontinue coverage unless the 50% minimum employer contribution is met and at least 75% of eligible employees have enrolled for coverage.

BCBSMT reserves the right to change premium rates when a substantial change occurs in the number or composition of members covered. A substantial change will be deemed to have occurred when the number of Employees/Members covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

Employer will promptly notify BCBSMT of any change in participation and Employer contribution.

**Additional Information/Comments**: City of Laurel provides a flat $ contribution as follows: - Employee: $784.69 Emp/Children: $784.69; $1,100 - Employee/Spouse; $1,100 - Family. Contribution towards Single Employee/Empl/Children changing from $767.87 to $784.69 at renewal

## BILLING SPECIFICATIONS

☒ **NO CHANGES**

The information provided within this section will be used to establish the format of your billing statement(s).

**Member list sorted by:** ☒ Unique Identification Number (standard) ☐ Social Security Number

**Please provide a detailed description of the preferred billing format** (for example: Billing statement to be broken out by Department, Location, Class): Active, Retirees Under 65; Retirees Over 65; COBRA

## ID CARD DELIVERY

☒ **NO CHANGES**

Mail ID Cards to:

- ☒ Member's home (standard)
- ☐ Account

## OTHER PROVISIONS

☐ **NO CHANGES**

1.) Electronic Issuance: The Employer consents to receive, via an electronic file or access to an electronic file, any Member Guide provided by BCBSMT to the Employer for delivery to each employee. The Employer further agrees that it is solely responsible for providing each Employee access to the most current version of any E-file Member Guide amendment, or other revised form provided by BCBSMT, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and holds BCBSMT harmless from any misuse of the E-file provided by BCBSMT.

☐ Accept – Employer consents to receive electronic versions of Member Guides for covered Employees.

☒ Decline – Employer does not consent to receive electronic versions of certificate-booklets for covered Employees or the Contract and desires BCBSMT to print and distribute hard copy versions.

Authorized Company Official's Initials: MM Date: 6/7/2016

2.) **Summary of Benefits & Coverage:** BCBSMT will create SBC (only for benefits BCBSMT insures under the Contract) and provide SBC to the Employer. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. The SBC Addendum is attached.

3.) **Association Plan.** Are you part of an association?

**If yes, please state the name of the Association:** _____

4.) This Application is incorporated into and made a part of the Contract entered into and agreed upon by BCBSMT and the account.

5.) Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

6.) **Reimbursement:** It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain twenty five percent (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

## ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide BCBSMT with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by BCBSMT to the terms and conditions of coverage. In no event shall BCBSMT be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the Application and Group Policy, and Employer represents and warrants that such Form is true, complete and accurate. If Employer fails to timely provide BCBSMT with any requested grandfathered health plan information, BCBSMT may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. If this Application includes any retiree only plans and/or excepted benefits, then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by BCBSMT to the terms and conditions of coverage. In no event shall BCBSMT be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. The provisions of paragraphs A-B (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

D. **ACA FEE NOTICE:** ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or "Health Insurer Fee"; and (2) the Transitional Reinsurance Program Contribution Fee or "Reinsurance Fee".

Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish a flat per member per month fee. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

Your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSMT reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSMT to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

**Additional Information:**

**I UNDERSTAND AND AGREE THAT:**

1. Producer Statement (if applicable): I certify that I have reviewed all enrollment materials. I have also advised the employer that I have no authority to bind these coverages, to alter the terms of the Contract(s), this Application or enrollment material in any manner or to adjust any claims for benefits under the Contract(s).
2. BCBSMT will report to ERISA plans with 100 or more participants the value of all remuneration paid by BCBSMT for use in the ERISA plans' preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.
3. The undersigned person represents that he/she is authorized and responsible for purchasing coverage on behalf of the employer. It is understood that the actual terms and conditions of coverage are those contained in the Contract into which this Application shall be incorporated at the time of acceptance by BCBSMT. Upon acceptance, BCBSMT shall issue a Contract to the employer and the employer shall be referred to as the "Employer or Contractholder."
4. The Employer's Group Application must pre-date the requested effective date and be received at BCBSMT at its Home Office no less than thirty (30) days prior to the requested effective date.

| | |
|---|---|
| Shellie Wherley | X |
| Authorized BCBSMT Representative | Signature of Authorized Purchaser |
| Account Executive | MAYOR |
| Title | Title |
| 6/7/2016 | 06/07/2016 |
| Date | Date |
| | |
| Producer Representative (if applicable) | |

## Summary of Benefits and Coverage Addendum
to the Large Group Application

First Date of Employer's Open Enrollment Period for the next Plan Year (the "First Open Enrollment Date"): June 1st

The Affordable Care Act ("ACA") requires group health plans and/or insurance issuers to create and distribute a Summary of Benefits and Coverage (or alternate format permitted by ACA) (the "SBC"), to participants and beneficiaries in certain specified situations (the "SBC Requirements"). In accordance with the Employer's election on the most current Application, to have BCBSMT create and/or distribute the SBC, as of the First Open Enrollment Date, the Employer acknowledges and agrees:

1. BCBSMT's SBC services do not include the creation or distribution of coverage information for benefits it does not insure under the Contract, unless otherwise agreed to in the Application or this Addendum.

2. The Employer is responsible for the proper synthesizing of information from its various insurers and administrative service providers it uses for its group health plan (or providing multiple partial SBCs if permitted by law).

3. The Employer is responsible for SBC services performed by The Employer's third party vendors.

4. The Employer must review and approve the SBC prior to distribution and is responsible for the content of the SBC. Nothing in this Addendum or in the Contract relieves the Employer or its group health plan of their respective legal and regulatory obligations with respect to the SBC.

5. ACA and the SBC regulatory and sub-regulatory guidance (the "Guidance") are new (and subject to change) and the regulatory agencies and industry interpretations thereof are evolving; therefore, BCBSMT 's operations shall not be considered to be in breach of this Addendum or the Contract to the extent has worked diligently and in good faith to provide the SBC services, based on a reasonable interpretation of then-current SBC-related ACA provisions and Guidance, in a manner consistent with the SBC Requirements.

6. The Employer agrees to furnish to BCBSMT in a timely manner all information necessary for the timely distribution of SBCs, including but not limited to names and addresses for: (i) any person currently enrolled in any plan administered or insured by BCBSMT, and (ii) any person the employer tells us is eligible or may become eligible. The Employer's failure to furnish such information, to agree to an implementation plan or to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSMT's SBC services and BCBSMT is relieved of its SBC obligations.

7. The Employer's failure to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSMT's SBC services thereby relieving BCBSMT of its SBC obligations arising under this Addendum or its associated Large Group Application.

8. BCBSMT may, but is not required to, monitor Employer's performance of its SBC obligations, audit the Employer with respect to the SBC, request and receive information, documents and assurances from the Employer with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations.) The Employer will notify BCBSMT of any actual or potential non-compliance with the SBC Requirements.

9. The Employer shall indemnify and hold harmless BCBSMT and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against BCBSMT in connection with the SBC (and the Employer's or its vendors' distribution of the SBC).

## PROXY

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

**Group No.:** 138764 By: Mark A. Mace
**Print Signer's Name Here**

➡ X Mark A Mace, MAYOR
**Signature and Title**

Group Name: City of Laurel

Address: 115 W. 1st Street

City: Laurel State: MT Zip Code: 59044

Dated this 7th day of June (Month) 2016 (Year)

# Option Sheet

Option chosen must be initialized by Group Leader or Officer of the Group

**Group Name:** City of Laurel 138674/138705
**Effective Date:** 07/01/2016
**Current Benefit:** Dual Option: Blue Dimensions PPO: $25 OVC Par Prof Providers; $500 Ind/$1,000 Family Deductible; 80/20 in-ntwrk; 65/35 Out-ntwrk co-ins; $2,000/$4,000 OOP

Current Rates

| Contract Type | | | | | |
|---|---|---|---|---|---|
| Single | | | | | $715.09 |
| Two Party | $1,584.00 | | | | $1,[illegible]00 |
| Emp/Chd(ren) | $1,138.00 | | | | $1,[illegible]0 |
| Family | $1,920.00 | | | | $1,[illegible]0 |
| S/Med | $400.00 | | | | $4[illegible]0 |
| 2P/Med | $799.00 | | | | $7[illegible]0 |

Group Leader Initials

Renewal Rates w/ CURRENT Benefits (Effective 07/01/2016)

Benefit: Dual Option: Blue Dimensions PPO: $25 OVC Par Prof Providers; $500 Ind/$1,000 Family Deductible; 80/20 in-ntwrk; 65/35 Out-ntwrk co-ins; $2,000/$4,000 OOP; Efficient RX

| Contract Type | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Single | $830.38 | | | | $830.38 | 16.3% | | $830.38 |
| Two Party | $1,842.19 | | | | $1,842.19 | 16.3% | | $1,842.19 |
| Emp/Chd(ren) | $1,321.17 | | | | $1,321.17 | 16.3% | | $1,321.17 |
| Family | $2,116.66 | | | | $2,116.66 | 16.3% | | $2,116.66 |
| S/Med | $465.20 | | | | $465.20 | 16.3% | | $465.20 |
| 2P/Med | $927.24 | | | | $927.24 | 16.3% | | $929.24 |

Group Leader Initials

**The following Options are available for your consideration:**

Option 1

Benefit Option 1: Blue Dimensions PPO: $25 OVC Par Prof Providers; $1000 Ind/$2,000 Family Deductible; 80/20 in-ntwrk; 65/35 Out-ntwrk co-ins; $2,500/$5,000 OOP; Efficient RX Fu

| Contract Type | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Single | [illegible] | | | | $784.69 | 9.9% | | $784.69 |
| Two Party | [illegible] | | | | $1,740.82 | 9.9% | | $1,740.82 |
| Emp/Chd(ren) | [illegible] | | | | $1,248.46 | 9.9% | | $1,248.46 |
| Family | [illegible] | | | | $2,000.18 | 9.9% | | $2,000.18 |
| S/Med | [illegible] | | | | $439.60 | 9.9% | | $439.60 |
| 2P/Med | [illegible] | | | | $878.10 | 9.9% | | $878.10 |

MPN
Group Leader Initials

Option 2

Benefit Option 2:

| Contract Type | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Single | | | | | | | | |
| Two Party | | | | | | | | |
| Emp/Chd(ren) | | | | | | | | |
| Family | | | | | | | | |
| S/Med | | | | | | | | |
| 2P/Med | | | | | | | | |

Group Leader Initials

Comments: Dual Option - Blue Dimensions
Prepared By: slw
Date: 04/20/2016

The following factors are used in setting rates: the income and claims experience for the 12 months prior to rating calculations for the category of product being rated; the benefit difference for the deductible and copayment relationship for the specific products in a product category; the projected claims, income, and enrollment for the next 12-month rating period; projected expenses for the plan of the next rating period; and/or age of the application or subscriber, industry, and risk characteristics.

The trend of premium increases during the preceding five years is: 2010 - 13%, 2011 - 13%, 2012 - 11%, 2013 - 11%, 2014 - 11%

# Option Sheet

Option chosen must be initialized by Group Leader or Officer of the Group

**Group Name:** City of Laurel 13567/138706
**Effective Date:** 07/01/2016
**Current Benefit:** Dual Option, Blue Dimensions PPO: $35 OVC Par Prof Providers, $1,000 Ind/$2,000 Family Deductible, 70/30 in-ntwrk, 55/45 Out-ntwrk co-ins, $3,000/$6,000 OC

| Contract Type | | | | | |
|---|---|---|---|---|---|
| Single | | | | | $6 00 |
| Two Party | | | | | $ 00 |
| Emp/Chd(ren) | | | | | $ 00 |
| Family | | | | | $ 00 |
| S/Med | | | | | $ 00 |
| 2P/Med | | | | | $ 00 |

Group Leader Initials

Benefit Dual Option, Blue Dimensions PPO: $35 OVC Par Prof Providers, $1,000 Ind/$2,000 Family Deductible, 70/30 in-ntwrk, 55/45 Out-ntwrk co-ins, $3,000/$6,000 OOP, Efficient F

| Contract Type | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Single | | | | | | 16.3% | | $780.37 |
| Two Party | | | | | | 16.3% | | $1,731.71 |
| Emp/Chd(ren) | | | | | | 16.3% | | $1,239.76 |
| Family | | | | | | 16.3% | | $1,988.73 |
| S/Med | | | | | | 16.3% | | $437.29 |
| 2P/Med | | | | | | 16.3% | | $874.58 |

Group Leader Initials

**The following Options are available for your consideration:**

**Benefit Option 1: Blue Dimensions PPO: $35 OVC Par Prof Providers, $1,500 Ind/$3,000 Family Deductible, 70/30 in-ntwrk, 55/45 Out-ntwrk co-ins, $3,500/$7,000 OOP, Efficient RX Fi**

| Contract Type | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Single | | | | | | | | $737.43 |
| Two Party | | | | | | | | $1,636.41 |
| Emp/Chd(ren) | | | | | | | | $1,171.53 |
| Family | | | | | | | | $1,879.29 |
| S/Med | | | | | | | | $413.22 |
| 2P/Med | | | | | | | | $826.45 |

Group Leader Initials

Benefit Option 2:

| Contract Type | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Single | | | | | | | | |
| Two Party | | | | | | | | |
| Emp/Chd(ren) | | | | | | | | |
| Family | | | | | | | | |
| S/Med | | | | | | | | |
| 2P/Med | | | | | | | | |

Group Leader Initials

Comments: Dual Option - Blue Dimensions
Prepared By: slw
Date: 04/20/2016

The following factors are used in setting rates: the income and claims experience for the 12 months prior to rating calculations for the category of product being rated, the benefit difference for the deductible and copayment relationship for the specific products in a product category, the projected claims, income, and enrollment for the next 12-month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics.

The trend of premium increases during the preceding five years is: 2010 - 13%, 2011 - 13%, 2012 - 11%, 2013 - 11%, 2014 - 11%

DELTA DENTAL

# SMALL BUSINESS PROGRAM
# GROUP DENTAL APPLICATION

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009
888-858-5252

## APPLICANT INFORMATION

| | | | |
|---|---|---|---|
| Name of Applicant: City of Laurel | | Fed. ID/TIN: 81-6001283 | |
| Contact: NEVA HALL | | Phone: 406-628-7431 x 4 | |
| Email: nhall@laurel.mt.gov | | Fax: clerk | |
| Address: PO Box 10 | | | |
| City: LAUREL | | State: MT ZIP Code: 59044 | County: Yellowstone |
| Industry Type: City | | SIC: 9199 | |
| Billing Address, if different: | | | |
| Billing Contact: NEVA HALL | | Phone: | Fax: |
| Billing Email: | | | |
| Situs State: Montana | Group Type: Employer | Contract Type: Non Retention | Length of Contract: One Year |
| Proposed Effective Date: July 1, 2016 | | | |
| Recipient of Electronic Documents and Notices: ☒ Applicant ☐ Other (provide name and email, address or fax number): | | | |
| Takeover: ☒ Yes ☐ No | | Name of prior carrier: DELTA (through Bank) | |

## DELTA DENTAL PPO℠ BENEFIT DESIGNS – Underwritten by Delta Dental Insurance Company

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Provider Reimbursement (check one)** | ☐ PPO<br>☒ PPO Plus Premier | | | | | | |
| **Select Plan** | ☒ A | ☐ A+ | ☐ B | ☐ D | ☐ Vol 1 | ☐ Vol 2 | ☐ Vol 3 |
| **Calendar Year Maximum (Per Enrollee)** | | | ☐ $1,000 | ☒ $1,500 | ☐ $2,000 | | |
| **D&P Maximum Waiver*[1]** | | | | ☒ Yes | ☐ No | | |
| **Orthodontic Services (Optional)** | | | | ☒ Yes | ☐ No | | |
| **Orthodontic Lifetime Maximum (Per Enrollee)** | | | | ☐ $1,000[2] | ☒ $1,500 | | |

## RATES AND FUNDING

**PPO Employer Contribution and Participation Requirement (check one):**

| | | | |
|---|---|---|---|
| ☐ 100%<br>All eligible employees | ☐ 75%-99.9%<br>75% of eligible employees | ☒ 50%-74.9%<br>50% of eligible employees | ☐ 0%-49.9%<br>(Voluntary Plans Only) |

For groups with 5 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 5 primary enrollees. For groups with 2-4 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.

[1] Variability available for A, A+, B, and D plans only.
[2] $500 applied to calendar year maximum for Vol 1, Vol 2 and Vol 3.

Note: Refer to Small Business Program brochure for specific plan information and underwriting guidelines.

| PPO Monthly Rates | | | |
|---|---|---|---|
| | Rates | #Primary Enrollees | Total |
| **2 Tier** | | | |
| EE Only | $ | x | = $ |
| EE & Family | $ | x | = $ |
| **3 Tier** | | | |
| EE Only | $ | x | = $ |
| EE+1 | $ | x | = $ |
| EE+2 or more | $ | x | = $ |
| **4 Tier** | | | |
| EE Only | $ 37.30 | x | = $ |
| EE+Spouse | $ 68.68 | x | = $ |
| EE+Child(ren) | $ 72.16 | x | = $ |
| EE+Family | $ 114.28 | x | = $ |
| | | **TOTAL** | $ |

## ELIGIBILITY INFORMATION

**Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):**

**# of Eligible Employees:** 60 | **# of PPO Enrolled Employees:**

**Eligible Individuals (check applicable boxes):** ☒ Eligible Employees ☐ Retired Employees

**Eligible Dependents (check applicable boxes):** ☒ Spouse ☒ Children ☐ Domestic Partner ☐ Other

**Eligible Requirement (check one):**
☐ Date of hire ☐ First of the month following date of hire ☒ First of the month following 0 days of employment

Application is herewith made for a dental insurance contract from Delta Dental Insurance Company (Delta Dental). It is understood that any variance to the underwriting criteria for this contract must be approved by Delta Dental prior to acceptance of the plan. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta Dental's designated administrator and accepted by the administrator on behalf for Delta Dental, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. It is understood that this Application is offered as an inducement for issuance of a dental insurance contract by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental from this Application and the terms of said contract will be issued separately. The contract will be deemed accepted and approved based on the Applicant's payment of premium after delivery of the contract. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant.

This plan shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Delta Dental we would not in good faith have issued the contract at the same premium rate. ***Applicant agrees that premiums and current eligibility list will be submitted to Delta Dental's designated administrator by the 25th of the month prior to the coverage month.***

Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta Dental's designated administrator with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta Dental agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental plan as described in the group dental insurance contract or as permitted or required by law. Delta Dental and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental insurance contract to be executed between the Applicant and Delta Dental.

Executed this 7th day of June 2016, for the Applicant at: LAUREL, MT
(City and State)

By: Mark A. Mace, Mayor Signature: X Mark A Mace
(Print Name and Title)

Delta Dental Authorized Signature: _____
(Anthony S. Barth, President)

| Delta Dental Administrator's Use ONLY | | Application accepted on: |
|---|---|---|
| TPA Employer #: | Delta Dental Group#: | |

## BROKER/AGENT INFORMATION

| | | | |
|---|---|---|---|
| Broker/Agent Name: DAVID J. ALLEN | State License: MONTANA 1001501 88 | | |
| Contact Email: dave@davealleninsurance.com | Phone: 406 656-2324 | Fax: 406 294-0276 | |
| Company Name: ALLEN & ASSOCIATES INSURANCE, INC | SSN/TIN: 47-4578199 | Is Company Inc.? ☒ Yes ☐ No | |
| Commission Mailing Address: 2048 OVERLAND AVE #203 | City: Billings | State: MT | ZIP Code: 59102 |
| Commission(s): 10% | Payable to: ALLEN & ASSOCIATES INSURANCE, INC | | |
| Broker/Agent Signature: | | Date: 5-31-16 | |

## GENERAL AGENT INFORMATION

| | | | |
|---|---|---|---|
| General Agent Name: Not Applicable | State License: | | |
| Contact Email: | Phone: | Fax: | |
| Company Name: | SSN/TIN: | Is Company Inc.? ☐ Yes ☐ No | |
| Commission Mailing Address: | City: | State: | ZIP Code: |
| Commission(s): | Payable to: | | |
| General Agent Signature: | | Date: | |

## ELECTRONIC DELIVERY OF DOCUMENTS TERMS AND CONDITIONS

**Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your Dental contract-related documents made available to you electronically. If you choose to have your contract-related documents made available to you electronically, the terms & conditions below apply.**

1. **Communication Methods: All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental or Delta Dental's designated administrator website with your user name and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.**
2. **Types of Documents that Will Be Electronically Communicated: Documents available electronically include, but are not limited to: your contract, the Evidence of Coverage (Certificate/EOC) for your enrollees and your notifications.**
3. **How to Withdraw Consent: You may withdraw your consent to transact business electronically by contacting Delta Dental's designated administrator. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic Communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.**
4. **How to Update Your Records: It is your responsibility to provide us with true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information by contacting Delta Dental's designated administrator.**
5. **Hardware and Software Requirements: In order to access, view, sign and retain electronic documents that we make available to you, you must:**
   - **Have a device that will connect to the Internet, access to an email account and access to an internet browser.**
   - **Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.**
   - **Be able to view the disclosures on your device.**
   - **Have sufficient storage capacity on your computer's hard drive or other data storage unit.**

**We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.**

☒ **Applicant has reviewed the Electronic Delivery Terms and Conditions above and consents to have contract-related documents provided electronically.**

# MONTHLY DUES ENDORSEMENT

## For

## CITY OF LAUREL

## Group No: 138674

This Endorsement is part of the Contract between Blue Cross and Blue Shield of Montana and
CITY OF LAUREL, Group No: 138674
The Effective Date of this Endorsement is 7/1/2016

| | | | | | | | Used when Medicare is Primary Coverage. These Rates Do Not Necessarily Indicate Retiree Coverage. | |
|---|---|---|---|---|---|---|---|---|
| **Benefit Type** | **Subscriber** | **Subscriber Spouse** | **Subscriber Dependent** | **Subscriber Dependents** | **Subscriber Spouse Dependent** | **Subscriber Spouse Dependents** | **Subscriber 65+** | **Subscriber Spouse 65+** |
| Blue Dimensions $1,000 | **$784.69** | **$1,740.82** | **$1,248.46** | **$1,248.46** | **$2,000.18** | **$2,000.18** | **$439.60** | **$878.10** |
| Blue Dimensions $1,500 | **$737.43** | **$1,636.41** | **$1,171.53** | **$1,171.53** | **$1,879.29** | **$1,879.29** | **$413.22** | **$826.45** |

This Endorsement is subject to the terms of the base Contract and all provisions of the base Contract, which do not conflict with this Endorsement, continue in full force. This Endorsement may be terminated or changed according to the provisions of the base Contract. This Endorsement will automatically terminate without notice when the base Contract terminates for any reason.

DuesEnd

DELTA DENTAL

Delta Dental Insurance Company

# Agent Fee Agreement

~~Allen & Associates~~ **Name of Agent** OR Allen & Associates Insurance, Inc. **Name of Company**

**Social Security Number** OR 47-4578199 **Federal Tax Identification Number**

City of Laurel **Group Name** | **Group Number** | 7/1/2016 **Effective Date**

Fees Payable to Agent

10 **% of the Premium/mo.;** OR $ _____ **per EE/mo.;** OR _____ **% of claims paid/mo.**

Agreement between **Agent** and **Delta Dental Insurance Company (Delta Dental)** is made as follows:

Delta Dental agrees to pay the Agent the fee stated above if said Agent:

1. is a licensed agent appointed by Delta Dental;
2. continues to be designated by the Group named above as its agent; and
3. performs services to the Group in a manner satisfactory to Delta Dental.

The Agent's fee shall be payable within 31 days following the month Delta Dental deposits premiums. If a rate adjustment is made for any period, then a corresponding adjustment shall be made in Agent's fee in the current period. Agent is not authorized to receive any monies due to Delta Dental without written authorization, signed by a Delta Dental officer and delivered to Agent. If any funds belonging or due to Delta Dental are received by Agent, they shall be deposited by Agent in a separate trust account and remitted in full to Delta Dental within five working days after receipt. Any funds not remitted to Delta Dental as provided herein shall bear interest at the rate of 8% per annum. In the event that suit is brought to collect monies due hereunder, Delta Dental shall be entitled to collect its costs of suit and a reasonable attorney's fee.

Any indebtedness of Agent to Delta Dental shall be first lien against any fees due to Agent or his representative or assigns under this Agreement and such fees shall be applied to liquidate such indebtedness.

No assignment, transfer or disposal of any interest that Agent may have on account of this Agreement shall be made at any time without written approval of Delta Dental.

Delta Dental may, at its option, be responsible for enrolling and servicing the Group and Agent hereby agrees to abide by the elected option of Delta Dental, but in either event, Agent agrees to render satisfactory services as directed by Delta Dental.

Agent recognizes that questions regarding eligibility and benefits are to be resolved by Delta Dental, the Group and the person claiming eligibility under the provisions of the dental health care contract with the Group. Agent shall reimburse Delta Dental for any benefits incurred by an Eligible Person as the result of erroneous information provided by Agent.

Agent shall notify Delta Dental within 48 hours of receipt of information from the Group, or any classification of employees within a Group, of its intention to terminate the Contract.

**Signature of Agent** Date 5-31-16

**Please print**

David J. Allen **Name of Signing Agent** | MT / 100150188 **State/Agent License Number**

2048 Overland Ave #203 **Address** | Billings **City** | MT **State** | 59102 **Zip** | (406) 656-2324 **Phone Number**

**Anthony S. Barth, President** Date

Form 3201 (Rev. 10-05)

## BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "BAA") is made and entered into as of the 1st day of July , 20 16 , by and between Delta Dental Insurance Company (the "Covered Entity") and City of Laurel (the "Business Associate").

**Definitions:**

Business Associate – "Business Associate" shall have the same meaning as the term "business associate" at 45 CFR §160.103, and in reference to the party to this agreement, shall be the party designated as a Business Associate in the first paragraph of this agreement.

Covered Entity – "Covered Entity" shall have the same meaning as the term "covered entity" at 45 CFR §160.103, and in reference to the party to this agreement, shall be the party designated as a Covered Entity in the first paragraph of this agreement.

Terms capitalized and used herein but not otherwise defined in this Business Associate Agreement ("BAA") shall have the same meaning as those terms are defined in the Health Insurance Portability and Accountability Act and related regulations found at 45 CFR Part 160 and Part 164, and the HITECH Act of 2009 (Health Information Technology for Economic and Clinical Health) as amended, revised or updated from time to time.

**I. Obligations and Activities of Business Associate.**

A. Business Associate may use or disclose Protected Health Information ("PHI") as follows:

1. as reasonably necessary to provide the services described in the separate primary agreement with Covered Entity ("Agreement"), and to undertake other activities of Business Associate permitted or required to satisfy its obligations under such Agreement;
2. as Required by Law;
3. for the proper management and administration of Business Associate, provided, that such use or disclosure is Required by Law;
4. to carry out the legal and compliance responsibilities of Business Associate; and
5. to report violations of law to appropriate Federal and State authorities.

B. Business Associate will:

1. use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Agreement;

2. conduct a risk assessment and implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI, which it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate acknowledges that the applicable provisions of the HIPAA Security Rule set forth at 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 are applicable to Business Associate;
3. agree to cooperate in a timely manner with the Covered Entity to make any amendments of PHI in its possession; and
4. will use reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

C. Business Associate shall take reasonable measures to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its agents or subcontractors in violation herein.

D. Business Associate will ensure through a separate, written Business Associate Agreement that any agent, including a subcontractor, to whom it provides or transmits PHI, including electronic PHI, agrees to restrictions and conditions that apply herein to Business Associate with respect to such information.

E. Business Associate shall promptly report to Covered Entity: (i) any use, disclosure or compromise of PHI not provided for herein, and (ii) any Security Incident.

F. Business Associate shall report to Covered Entity any Breach (or potential Breach) of Unsecured PHI as soon as possible without unreasonable delay but in no case later than thirty (30) calendar days after discovery of the Breach (except where a law enforcement official determines that such reporting would impede an investigation or cause damage to national security). Covered Entity shall have final determination as to whether a Breach has actually occurred. Where the Business Associate is also the Covered Entity, the Business Associate may issue the notification. The reporting required under this section shall include, to the extent practicable:

1. information that identifies the Individual(s) whose Unsecured PHI has been or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Breach;
2. a brief description of what happened;
3. a description of the Unsecured PHI involved in the Breach;

4. steps that the Individual(s) could take to protect him/herself from potential harm; and
5. a brief description of steps taken by Business Associate to investigate, mitigate or protect against the Breach.

G. To the extent applicable, Business Associate shall provide PHI contained in a Designated Record Set held by Business Associate (that is not duplicative of PHI in possession of Covered Entity) to Covered Entity in order for Covered Entity to meet the requirements under 45 CFR §164.524 or 45 CFR §164.526, as applicable. If any Individual requests access to his or her PHI directly from Business Associate, Business Associate shall forward such request to Covered Entity so that Covered Entity can comply with the request. Any disclosure of, or decision not to disclose, the PHI requested by an Individual or a personal representative and compliance with the requirements applicable to an Individual's right to obtain access to PHI shall be the sole responsibility of the Covered Entity. If the PHI that is requested is maintained electronically and the Individual requests an electronic copy of such information, Business Associate will provide access to the information in an electronic format that complies with 45 CFR § 164.524(c)(2)(ii).

H. Business Associate shall document 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. Business Associate shall provide to Covered Entity, within a timeframe mutually agreed to by Covered Entity and Business Associate, information collected in accordance with this Section, 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. If any Individual requests access to the foregoing information directly from Business Associate, Business Associate shall forward such request to Covered Entity so that Covered Entity can comply with the request.

I. Business Associate agrees to make its internal practices, books and records, including policies and procedures, 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 Secretary of Health and Human Services (HHS), in a time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

J. Business Associate acknowledges that the additional requirements of the HITECH Act (Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009) and

the Final Rule (also known as Omnibus Rule) issued by HHS on January 25, 2013 are applicable to Business Associate as described therein. Business Associate further acknowledges restrictions on the sales and marketing of PHI without the explicit authorization of the Individual.

K. In the event the Business Associate independently is also a Covered Entity under HIPAA, the Business Associate may respond directly to an Individual's request for purposes of complying with applicable sections herein.

L. Any costs associated with Breach notifications, including mitigation costs, shall be the responsibility of the party causing the Breach.

## II. Obligations of Covered Entity.

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

B. Covered Entity shall:

1. notify Business Associate of any limitations in Covered Entity's Notice of Privacy Practices in accordance with 45 CFR § 164.520, if such limitations may affect Business Associate's use or disclosure of PHI;
2. provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes may affect Business Associate's use or disclosure of PHI, upon Covered Entity becoming aware of such changes;
3. immediately notify Business Associate of any restriction to the use or disclosure of PHI agreed to by Covered Entity in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI;
4. provide written authorization to the Business Associate prior to requesting that the Business Associate disclose, transfer or provide PHI to a third party; and
5. where applicable, rely on the plan sponsor's representations certifying amendments to their plan documents with appropriate restrictions covering their use and disclosure of PHI.

## III. Term and Termination.

A. The term of the BAA shall commence on the Effective Date and shall continue in full force and effect until it expires or is terminated as set forth herein.

B. This BAA may be terminated by Covered Entity if Business Associate materially breaches these terms or its Agreement and fails to cure such breach within fifteen (15) business days after receipt of written notice of the breach. This BAA will automatically terminate upon the expiration or termination of the Agreement (or such portion of the Agreement which gave rise to the requirement for this Business Associate Agreement). If, in its reasonable discretion following consultation with the other party, that neither termination of this BAA nor a cure is feasible; the non-breaching party may report the breach to the Secretary.

C. Upon expiration or termination of this BAA for any reason, Business Associate will return or destroy all PHI to Covered Entity. Business Associate shall not retain any copies of the PHI. However, to the extent that Business Associate determines that it is infeasible to return or destroy Covered Entity's PHI, Business Associate shall notify Covered Entity in writing of the conditions that make return or destruction infeasible. For any PHI for which return or destruction is infeasible, Business Associate will continue to extend the protections of this Addendum 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. If Business Associate elects to destroy all PHI, it shall, if requested in writing by Covered Entity, certify in writing to Covered Entity that such PHI has been destroyed.

The terms of this section shall survive the expiration or termination of this BAA.

## IV. Confidential Information

A. "Confidential Information" means any information disclosed by or on behalf of a Party ("Disclosing Party") to the other Party ("Receiving Party") whether provided orally or in writing and on whatever medium, concerning the Disclosing Party's business and/or operations and includes without limitation any materials, trade secrets, know-how, formulas, processes, policies and procedures, training materials, IT security, algorithms, ideas, strategies, inventions, data, designs, flow charts, drawings, proprietary information, business and marketing plans, financial and operational information, and all other non-public information, material or data relating to the current and/or future business and operations of the Disclosing Party.

B. Confidential Information shall not include any information that:

1. is already in the public domain at the time of disclosure or later becomes available to the public through no breach of this Agreement by the Receiving Party or its employees;

2. is lawfully in the Receiving Party's possession, without an obligation of confidentiality, prior to receipt hereunder;
3. is received independently by the Receiving Party from a third party who was free to lawfully disclose such information to the Receiving Party; or
4. is independently developed by the Receiving Party without the use of Confidential Information as evidenced by the Receiving Party's business records.

C. The Receiving Party agrees to use at least the same degree of care, and no less than reasonable care, to avoid disclosure of such Confidential Information as the Receiving Party uses with respect to its own proprietary or Confidential Information of like importance.

**V. Amendment to Comply with Law.**

The parties agree to take such action as is necessary to comply with and implement the standards and requirements of HIPAA (including, without limitation, the prompt amendment of this BAA). Notwithstanding the foregoing, if Covered Entity and Business Associate have not amended this Agreement to address a law or final regulation that becomes effective after the Effective Date and that is applicable to this Agreement, then upon the effective date of such law or regulation (or any portion thereof) this Agreement shall be amended automatically and deemed to incorporate such new or revised provisions as are necessary for this Agreement to be consistent with such law or regulation and for Covered Entity and Business Associate to be and remain in compliance with all applicable laws and regulations.

**VI. Interpretation.**

If a term in Agreement conflicts or is otherwise inconsistent with a term in this BAA, the provisions of this BAA will prevail with respect to the subject matter hereof. This BAA and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA.

**VII. Indemnification.**

The Parties agree that the indemnification provision contained in the Agreement between the Business Associate and the Covered Entity shall apply to each party's performance and that of their respective agents or subcontractors under this BAA.

**Covered Entity:**

Signature:

Printed Name: Kevin Jackson

Title: Group Vice President Underwriting & Actuarial

Organization: Delta Dental Insurance Company

**Business Associate:**

Signature: X Mark A Mace

Printed Name: Mark A. Mace

Title: Mayor

Organization: City of Laurel

Date: 06/07/2016

DELTA DENTAL

# Small Business Program Rates

| | | | | | |
|---|---|---|---|---|---|
| Group: | City of Laurel | Date of Quote: | 05/09/2016 | County: | Yellowstone |
| Broker: | Allen & Associates | Effective Date: | 07/01/2016 | SIC Code: | 9199 |
| Prior Coverage: (Takeover) | Yes | State/ZIP: | MT 591 | Group Size: | 60 |

| | Option 1 | Option 2 | Option 3 | Option 4 | Option 5 |
|---|---|---|---|---|---|
| Plans | Plan A | Plan A | | | |
| Plan / Fee Basis* | PPO in/MPA out | PPO in/MPA out | | | |
| Diagnostic & Preventive | 100% | 100% | | | |
| Basic | 80% | 80% | | | |
| Major | 50% | 50% | | | |
| Endo / Perio | Basic | Basic | | | |
| Oral Surgery | Basic | Basic | | | |
| Deductible | $50/$150 | $50/$150 | | | |
| waived on D & P | Yes | Yes | | | |
| Annual Max | $1,500 | $1,500 | | | |
| waived on D & P | Yes | Yes | | | |
| Child Ortho Life Benefit | 50% to $1,500 | 50% to $1,500 | | | |
| Contribution | 75% to 100% | 50% to 74.9% | | | |
| Waiting Period** | none | none | | | |
| 2 Tier Rates | | | | | |
| Enrollee | $35.12 | $37.30 | | | |
| Enrollee + Family | $91.66 | $93.83 | | | |
| 3 Tier Rates | | | | | |
| Enrollee | $35.12 | $37.30 | | | |
| Enrollee + 1 | $65.16 | $67.34 | | | |
| Enrollee + 2 or more | $110.00 | $112.17 | | | |
| 4 Tier Rates | | | | | |
| Enrollee | $35.12 | $37.30 | | | |
| Enrollee + Spouse | $66.51 | $68.68 | | | |
| Enrollee + Child(ren) | $69.99 | $72.16 | | | |
| Enrollee, Sp & Children | $112.10 | $114.28 | | | |
| Group Number | MT-15937-51613 | MT-15937-51611 | | | |

* See "Products Quoted" page for explanation.

** Waiting period applies to the voluntary plans only. For Vol 1 & Vol 2 plans, it applies to major and orthodontic services if covered. For Vol 3 plans, it applies to endo, perio, oral surgery, major and orthodontic services if covered. The waiting period is waived for all employees with continuous coverage under this employer's prior comprehensive dental plan.

## Informational Purposes

This proposal is for informational purposes only and is not a contract. Rates quoted are based on the information provided at the time the quotation was released. Rates are not valid unless accompanied by plan benefits and limitations and exclusions. Rates quoted are for a one-year contract period.

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009
(770) 641-5100
(888) 858-5252

# Delta Dental PPO℠ Group Dental Insurance Contract

**CITY OF LAUREL**, ("Contractholder") has applied for a group dental insurance Contract with Delta Dental Insurance Company ("Delta Dental"). The following terms will apply:

I. Contractholder will pay Delta Dental the monthly Premium stated in this Contract.

II. Delta Dental has accepted the application submitted and signed by the Contractholder. When the Contractholder pays the first month's Premium, the term of this Contract will begin at 12:01 a.m. Standard Time, on the Effective Date listed in Attachment C, Group Variables (Attachment C). The term of this Contract will end as stated in this Contract at the end of the Contract Term at 12:00 midnight Standard Time.

III. Contractholder will provide each Primary Enrollee electronic access to a certificate/Evidence of Coverage booklet supplied by Delta Dental. Delta Dental will also furnish a hard copy to a Primary Enrollee or the Contractholder upon request. Contractholder will also distribute to its Enrollees any notice from Delta Dental which may affect their rights under this Contract.

So long as Contractholder pays the Premiums as stated in Article 3, Delta Dental agrees to provide the Benefits described in this Contract including Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A) and Attachment B Services, Limitations and Exclusions (Attachment B).

This Contract is issued and delivered in the State of Montana and is governed by its laws.

Delta Dental Insurance Company

Belinda Martinez

Belinda Martinez, President

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## ARTICLE 1 - DEFINITIONS

Terms when capitalized in this document have defined meanings, given either in the section below or within this Contract's sections.

1.01 **Accepted Fee** -- the amount the attending Provider agrees to accept as payment in full for services rendered.

1.02 **Benefits** -- the amounts that Delta Dental will pay for covered dental services under this Contract.

1.03 **Calendar Year** -- the 12 months of the year from January 1 through December 31.

1.04 **Claim Form** -- the standard form used to file a claim or request a Pre-Treatment Estimate.

1.05 **Contract** -- this agreement between Delta Dental and the Contractholder, including the attachments listed in Article 7.

1.06 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Delta Dental will pay after the Deductible has been satisfied as shown in Attachment A.

1.07 **Contractholder** -- the employer contracting to obtain Benefits.

1.08 **Contract Term** -- the period during which this Contract is in effect, as shown in Attachment C.

1.09 **Contract Year** -- the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

1.10 **Deductible** -- a dollar amount that an Enrollee and/or the Enrollee's family (for family coverage) must pay for certain covered services before Delta Dental begins paying Benefits.

1.11 **Delta Dental PPO Contracted Fee** -- the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for covered services.

1.12 **Delta Dental PPO Provider (PPO Provider)** -- a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental PPO Contracted Fee as payment in full for covered services provided under a PPO dental plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

1.13 **Delta Dental Premier® Contracted Fee** -- the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services.

1.14 **Delta Dental Premier Provider (Premier Provider)** -- a Provider who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

1.15 **Dependent Enrollee** -- an Eligible Dependent enrolled to receive Benefits.

1.16 **Effective Date** -- the original date this Contract starts, as shown in Attachment C.

1.17 **Eligible Dependent** -- a dependent of an Eligible Employee eligible for Benefits under Article 2.

1.18 **Eligible Employee** -- any employee or retiree (if applicable) eligible for Benefits under Article 2.

1.19 **Enrollee** -- an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

1.20 **Enrollee's Effective Date of Coverage** -- the date the Contractholder reports coverage will begin for each Primary Enrollee and each Dependent Enrollee.

1.21 **Maximum Contract Allowance** -- the reimbursement under the Enrollee's benefit plan against which Delta Dental calculates payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Program Allowance.

1.22 **Non-Delta Dental Provider** -- a Provider who is not a PPO Provider or a Premier Provider and who is not contractually bound to abide by Delta Dental's administrative guidelines.

1.23 **Open Enrollment Period** -- the month of the year during which employees may change coverage for the next Contract Year.

1.24 **Patient Pays** -- Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Delta Dental Pays" on the claims statement when a claim is processed.

1.25 **Pre-Treatment Estimate** -- an estimation of the allowable Benefits under this Contract for the services proposed, assuming the person is an eligible Enrollee.

1.26 **Premium** -- the amounts payable by the Contractholder monthly as provided in Attachment C.

1.27 **Primary Enrollee** -- an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee."

1.28 **Procedure Code** -- the Current Dental Terminology® ("CDT") number assigned to a Single Procedure by the American Dental Association.

1.29 **Program Allowance** -- the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

1.30 **Provider** -- a person licensed to practice dentistry when and where services are performed or a licensed denturist in the state of Montana. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

1.31 **Qualifying Status Change** -- a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Enrollee or Eligible Dependent);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, dependent Spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

1.32 **Single Procedure** -- a dental procedure that is assigned a separate Procedure Code.

1.33 **Spouse** -- a person related to or a partner of the Primary Enrollee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Primary Enrollee resides; and
- as may be recognized by the Contractholder.

1.34 **Submitted Fee** -- the amount that the Provider bills and enters on a claim for a specific procedure.

## ARTICLE 2 - ELIGIBILITY AND ENROLLMENT

2.01 **Reporting**
Delta Dental processes eligibility as reported by the Contractholder. On or before the Effective Date, Contractholder will furnish to Delta Dental, in writing or via electronic format as agreed by Delta Dental and the Contractholder, a listing of eligible Primary Enrollees and Dependent Enrollees. Electronic format may be file transmissions, Delta Dental's web tool or a combination of the two. The listing shall include, but not be limited to, the:

- Primary Enrollees' and Dependent Enrollees': names, Enrollee ID numbers, Enrollee's Effective Date of Coverage, dates of birth, addresses and gender;
- Dependent Enrollees' dependent status; and
- Primary Enrollees' location, if applicable.

The eligibility list shall include all Eligible Employees unless the Eligible Employee waives coverage or enrolls in an alternate dental plan offered by Contractholder. The eligibility list may also include retired employees, if applicable.

Thereafter, before the tenth day of each month, Contractholder must furnish to Delta Dental in the format agreed to above, a listing indicating specific additions, changes or terminations made during the prior month. An Enrollee remains enrolled until the Contractholder notifies Delta Dental of the termination. If the Primary Enrollee loses coverage or makes any change that affects an Enrollee's eligibility, Contractholder must promptly notify Delta Dental of such change.

Contractholder will notify Delta Dental in writing or in electronic media of any requests for Premium adjustments for Enrollees who should have been terminated in the event Delta Dental was not previously notified of the termination(s). Retroactivity will be adjusted up to the immediately preceding three (3) months plus the current billing month.

Delta Dental will not make any payment for services provided to an Enrollee who is not reported to Delta Dental as an Enrollee under this Contract when the service is provided. Also, Delta Dental may not pay Benefits for an Enrollee if Premiums are not paid for the month in which dental services are rendered. Delta Dental shall not be obligated to recover claims paid to a Provider as a result of Contractholder's retroactive eligibility adjustments. The Contractholder agrees to reimburse Delta Dental for any erroneous claim payments made by Delta Dental as a result of incorrect eligibility reporting by the Contractholder.

2.02 Contractholder will permit Delta Dental to audit Contractholder's records to confirm compliance with Articles 2 and 3. Delta Dental will give Contractholder written notice within a reasonable time before the audit date.

2.03 **Eligible Employees**
Full-time Eligible Employees will become eligible to receive benefits on the date stated in the application after completing any eligibility periods required by the Contractholder.

2.04 **Eligible Dependents**

- Dependents are the Primary Enrollee's Spouse, a child from birth to age 26 or a child of any age who is disabled and dependent upon the Eligible Enrollee.
- Children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as recognized by the Contractholder. Newborn infants of any person covered under this Contract are eligible from and after the moment of birth regardless of dependent status. Adopted children are eligible from the date of placement for adoption or final decree of adoption, whichever occurs first. The dependents of Primary Enrollees are eligible to enroll on the same date that the employee becomes a Primary Enrollee. Later-acquired dependents become eligible as soon as they acquire dependent status.
- An overage dependent child may be eligible if:
  1) he/she is incapable of self-sustaining employment by reason of intellectual disability or physical disability that began before he/she reached the limiting age;
  2) he/she is chiefly dependent on the Eligible Employee for support and maintenance; and
  3) proof of dependent child's intellectual disability or physical disability and dependency is provided within 31 days of the child's attainment of the limiting age. Such requests will not be made more than once a year following a two year period after this dependent child reaches the limiting age. Enrollment will continue as long as the dependent child relies on the Eligible Employee for support by reason of intellectual disability or physical disability and dependency that began before he/she reached the limiting age.

Dependents on active military duty are not eligible.

2.05 **Enrollment of Eligible Employees and Eligible Dependents**

- If Contractholder pays the entire cost of coverage for all Primary Enrollees and Dependent Enrollees, all Eligible Employees and Eligible Dependents are automatically covered under the plan.
- If the Primary Enrollee must contribute any portion of the cost of coverage, then Eligible Employees must enroll to be covered under the plan. Enrollment must be within 31 days after first becoming eligible or during an Open Enrollment Period. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- If the Primary Enrollee is paying all or a portion of the cost for coverage for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental, then Eligible Dependents must be enrolled within 31 days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- All Eligible Dependents without dental coverage under another plan must be enrolled as Dependent Enrollees if dependent coverage is elected.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under this Contract as a Primary Enrollee or a Dependent Enrollee but not both at the same time.

2.06 Except for an employee absent from work due to a leave of absence governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), an Enrollee will not be covered for any dental services received while a Primary Enrollee is on strike, lay-off or leave of absence. Contractholder must inform Delta Dental of any change in eligibility as required under section 2.01.

Benefits for such Primary Enrollee and his/her Eligible Dependents will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and Maximums will resume as if the Primary Enrollee were never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and Maximums will apply.

Coverage will resume the first day of the month after the Primary Enrollee returns to work, provided the Contractholder submits the request to Delta Dental that coverage be reactivated.

If an employee is rehired within the same Calendar Year, Deductibles and Maximums will resume as if the Primary Enrollee was never gone.

2.07 A Primary Enrollee loses coverage on the earlier of the last day of the month of employment, when he/she is no longer an Eligible Employee of the Contractholder or the day this Contract is terminated. Dependent Enrollees lose coverage along with the Primary Enrollee or when dependent status is lost.

*Termination of Benefits on Loss of Eligibility*
Delta Dental will not pay for Benefits for any services received by a person who is not an Enrollee at the time of treatment except for covered dental services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

2.08 **Continued Coverage Under MMSERA**
As required under the Montana Military Service Employment Rights Act ("MMSERA"), an Enrollee covered by this Contract on the date his/her state active duty begins:

- may elect not to continue coverage during the state active duty and upon return to employment with the Contractholder resume coverage under this Contract as though no leave of absence occurred; or
- may elect to continue coverage during the state active duty without paying more than the regular employee share of the cost of coverage unless your state active duty qualifies you for coverage under the state of Montana's health plan as an employee of the Department of Military Affairs.

2.09 **Continued Coverage Under USERRA**
As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if a Primary Enrollee is covered by this Contract on the date his/her USERRA leave of absence begins, the Primary Enrollee may continue dental coverage for himself/herself and any covered Dependent Enrollees. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins; or
- the date the Primary Enrollee fails to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

2.10 **Continued Coverage Under COBRA**
When the Eligible Employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Delta Dental agrees to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- continuation of coverage is required to be offered under COBRA;
- the Enrollee requests the continuation within the time frame allowed;
- the Contractholder notifies Delta Dental that the Enrollee has elected to continue coverage under COBRA;
- Delta Dental receives the required Premium for the continued coverage; and
- this Contract stays in force.

Delta Dental does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

2.11 **Multiple Plan Options, if applicable**
This Contract is entered into with the understanding that Eligible Employees of the Contractholder have a choice between dental coverage under this Delta Dental plan and one or more alternate programs. Eligible Employees may exercise that choice as follows:

- All Eligible Employees that enroll will be enrolled as Primary Enrollees under the Delta Dental plan unless they elect an alternate plan.
- Except for new employees, enrollment may be filed with Contractholder only during the Open Enrollment Period.
- New employees may enroll within 31 days of employment which will be effective until the next Open Enrollment Period.

## ARTICLE 3 – MONTHLY PREMIUMS

3.01 Contractholder will remit to Delta Dental or its Third Party Administrator the Premium in the amount and manner shown in Attachment C for all Primary Enrollees and Dependent Enrollees.

Delta Dental will process eligibility as reported by the Contractholder.

3.02 This Contract will not be in effect until Delta Dental receives the first month's Premiums. Subsequent Premiums will be paid by the first day of each month. For each Premium after the first, a grace period of 30 days from the due date will be allowed for the payment of the Premium. This Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, this Contract may be terminated by Delta Dental in accordance with the notice requirements of section 6.01.

3.03 If this Contract is terminated before the end of a Contract Term, Contractholder will pay additional charges in accordance with Article 6.

3.04 Delta Dental will not be responsible or liable for any incorrect, incomplete, obsolete or unreadable data or information supplied to Delta Dental including, but not limited to, eligibility and enrollment information.

3.05 Delta Dental may change the monthly Premium whenever this Contract is amended as stated in section 3.06, or whenever the Contractholder requests a change in Benefits, eligibility or when due to a state and/or federal mandated change. Any change in Premium shall not be effective during a Contract Term unless Contractholder and Delta Dental agree in writing and a change in Premium may not be made more frequently than once during a 12-month period, except as provided in section 3.06, 3.07 or necessitated by a state or federal law, court decision or rule adopted by an agency or competent jurisdiction of the state or federal government.

3.06 Premiums are based on the composition of the Contractholder's group at the beginning of each Contract Term. Delta Dental may propose a choice of changes in Premiums or Benefits for a 15 percent change in composition during the Contract Term, such as an increase or decrease in enrollment, change in location, change in job classifications, change in mix of active versus retiree enrollment or other similar change in the Contractholder's group composition that lasts three (3) months in a row or longer and results in an increase in cost per person of the Contractholder's group. Within 31 days of receipt of the proposed change(s), Contractholder will select one of the choices by written notice to Delta Dental. If Contractholder fails to do so, Delta Dental may select one of the choices by written notice to Contractholder. This Contract will be modified for all dental services predetermined and incurred after notice.

3.07 If, during the Contract Term, any new or increased tax, assessment or fee is imposed on the amounts payable to, or by, Delta Dental under this Contract or any immediately preceding contract between Delta Dental and Contractholder, the Premium amount stated in Attachment C will be increased by the amount of any such new or increased tax, assessment or fee with at least 60 days' advance written notice to Contractholder, and this Contract shall thereby be modified on the date set forth in the notice.

## ARTICLE 4 - CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

4.01 Delta Dental will pay Benefits for dental services described in Attachment B when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Claims shall be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised from time to time; therefore, Delta Dental shall use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person is an Enrollee under any Delta Dental program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are shown in Attachment A. If an Enrollee receives dental services from a Provider outside the state of Montana, the Provider will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of this Contract.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

A Provider may charge more than the limits of this Contract and, subsequently, may not be covered under the terms of this Contract. A PPO Provider's Contracted Fee is 20% less than Delta Dental's Montana 80$^{th}$ percentile Program Allowance which represents the amount that 80% of Providers in the state will accept as payment in full. Delta Dental's Montana 80$^{th}$ percentile Program Allowances are state-wide and are determined by the fees filed by Premier Providers in the Participating Dentist Agreement and Delta Dental's proprietary fee data. Premier Providers can file their fees at any time. Delta Dental's proprietary fee data is based on amounts submitted to Delta Dental by Providers that practice in the state of Montana.

4.02 Delta Dental's provision of Benefits is limited to the applicable portion of the Provider's fees or allowances specified in Attachment A. The Enrollee is responsible for paying the balance of any fees or allowances known as the "Enrollee Coinsurance." Contractholder has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of such Enrollee Coinsurance fees or allowances that are discounted, waived or rebated.

4.03 **Deductible**
As shown on Attachment A, Delta Dental will not pay Benefits for the Deductible amount of the Maximum Contract Allowance for services received each Calendar Year by an Enrollee. The annual maximum Deductible per family, if any, is shown in Attachment A. Only fees an Enrollee pays for covered services that are described in Attachment B will count toward the Deductible.

4.04 **Maximum**
A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount Delta Dental will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Delta Dental will pay the Maximum Amount(s), if applicable, shown in Attachment A for Benefits under this Contract.

4.05 **Choice of a Provider**
Enrollees may choose a Provider from Delta Dental's panel of PPO and Premier Providers or Enrollees may choose a Non-Delta Dental Provider. A list of PPO and Premier Providers can be obtained at Delta Dental's website (deltadentalins.com). Providers are regularly added to or deleted from the list. Enrollees are responsible for verifying whether the selected Provider is a PPO Provider or a Premier Provider. Additionally, Enrollees should always confirm with the Provider's office that a listed Provider is still a participating PPO Provider or Premier Provider. Delta Dental does not guarantee that any particular Provider will be available.

*PPO Provider*
Selecting a PPO Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

*Premier Provider*
A Premier Provider has not agreed to the features of the PPO program; however, Enrollees may still receive dental care at a lower cost than if Enrollees use a Non-Delta Dental Provider.

*Non-Delta Dental Provider*
If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by the PPO Providers or Premier Providers. For a Non-Delta Dental Provider, the Accepted Fee is the Provider's Submitted Fee.

*Additional Obligations of Delta Dental Providers:*
- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of the Deductible and Enrollee Coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.
- The PPO Provider or Premier Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and contracted fees.

4.06 **Coordination of This Contract's Benefits with Other Benefits**
The Coordination of Benefits ("COB") provision applies when an Enrollee has health care coverage under more than one plan. Delta Dental coordinates the Benefits under this Contract with an Enrollee's benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the "Primary Plan." The Primary Plan must pay benefits in accordance with its contract terms without regard to the possibility that another plan may cover some expenses. If this Contract is the Primary Plan, Delta Dental will not reduce Benefits.

The plan that pays after the Primary Plan is the "Secondary Plan." If this Contract is the Secondary Plan, Delta Dental may reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense. Additionally, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

*Definitions of Terms Used in this Section*

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   (1) Plan includes: group and non-group health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

   (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, if determined by the commissioner to be "excepted benefits" as defined in 33-22-140, MCA; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This Plan means, in this COB provision, this Contract providing the dental care Benefits to which this COB provision applies and which may be reduced because of the benefits of other plans.

C. The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

   When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and may reduce the Benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense ("Allowable Expense").

D. Allowable Expense is a health or dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a Provider, by law or in accordance with a contractual agreement, is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) If an Enrollee is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If an Enrollee is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If an Enrollee is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and, if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health or dental care benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

*Order of Benefit Determination Rules*

When an Enrollee is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in paragraph (2), a Plan that does not contain a COB provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the Spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the Spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

*Effects on the Benefits of This Plan*

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If an Enrollee is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that Plan and other closed panel plans.

*Right to Receive and Release Needed Information*

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Delta Dental may obtain facts needed from or provided to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Delta Dental any facts it needs to apply those rules and determine benefits payable.

*Facility of Payment*

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

*Right of Recovery*

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

*COB Disputes*

If an Enrollee believes that Delta Dental has not paid a claim properly under this COB provision, he/she should first attempt to resolve the dispute by contacting Delta Dental at (800) 521-2651. If the Enrollee is still not satisfied, he/she may contact the Montana Commissioner of Securities and Insurance at (406) 444-2040 or (800) 332-6148.

4.07 **Clinical Examination**
Before approving a claim, Delta Dental may obtain, to such extent as may be lawful, from any Provider, or from hospitals in which a Provider's care is provided, such information and records relating to an Enrollee as Delta Dental may require to administer the claim. Delta Dental may also require that an Enrollee be examined by a dental consultant retained by Delta Dental at Delta Dental's expense in or near his/her community or residence. Such information and records will be kept confidential in accordance with all applicable laws and regulations.

4.08 **Notice of Claim Forms**
Delta Dental will furnish to any Provider or Enrollee, on request, a Claim Form to make a claim for payment of Benefits. To make a claim, the Claim Form must be completed and signed by the Provider who performed the services and by the Enrollee (or the parent or guardian of a minor) and submitted to Delta Dental at the address shown thereon. If Delta Dental does not furnish the Claim Form within 15 days after requested by a Provider or Enrollee, the requirements for proof of loss set forth in section 4.10 of this Contract will be deemed to have been complied with upon the submission to Delta Dental within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. Enrollees and Providers may download a Claim Form from Delta Dental's website.

4.09 **Pre-Treatment Estimate**
A Provider may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will estimate the amount of Benefits payable under this Contract for the listed services. Benefits will be processed according to the terms of this Contract when the treatment is performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date this Contract terminates;
- the date Benefits under this Contract are amended if services in the Pre-Treatment Estimate are part of the amendment;
- the date the Enrollee's coverage ends; or
- the date the Provider's agreement with Delta Dental ends.

4.10 **Written Notice of Claim/Proof of Loss**
Delta Dental must be given a written notice of claim, sometimes referred to as a written proof of loss, within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta Dental within 12 months of the termination of this Contract.

4.11 **Time of Payment**
Claims payable under this Contract for any loss other than for which this Contract provides any periodic payment will be paid no later than 30 days after written proof of loss is received. Delta Dental will notify the Primary Enrollee and his/her Provider of any additional information needed to process the claim within this 30 day period.

Delta Dental will pay interest equal to the amount of the claim due plus 10 percent annual interest calculated from the date the claim was due if a claim is not paid or denied:

- within 30 days of receiving written proof of loss if no additional information is requested; or
- within 60 days of receiving all requested information if additional information is requested.

Interest is only payable if the amount due exceeds $5 and interest payments will be made to the person who receives the claims payment.

4.12 **Claims Appeal**
Delta Dental will notify the Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee has at least 180 days after receiving a notice of denial to request a grievance by writing to Delta Dental giving reasons why they believe the denial was wrong. The Enrollee and his/her Provider may also ask Delta Dental to examine any additional information provided that may support the grievance.

Send the grievance to Delta Dental at the address shown below:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Delta Dental will send the Enrollee a written acknowledgment within five (5) days upon receipt of the grievance. Delta Dental will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Contract, Delta Dental shall consult with a dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. Delta Dental will send the Enrollee a decision within 30 days after receipt of the Enrollee's grievance.

If the Enrollee believes he/she needs further review of their grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration ("EBSA"), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

4.13 **To Whom Benefits Are Paid**
Payment for services provided by a PPO Provider or a Premier Provider will be made directly to the Provider. Any other payments provided by this Contract will be made to the Primary Enrollee unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to the Primary Enrollee, to his/her estate, or to an alternate recipient as directed by court order except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

4.14 No change in Benefits will become effective during a Contract Term unless Contractholder and Delta Dental agree in writing.

## ARTICLE 5 - GENERAL PROVISIONS

5.01 **Entire Contract: Changes**
This Contract, including the attachments listed in Article 7, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of Delta Dental.

5.02 **Severability**
If any part of this Contract 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 Contract will remain in full force and effect.

5.03 **Conformity with Prevailing Laws**
All legal questions about this Contract will be governed by the state of Montana where this Contract was entered into and is to be performed. Any part of this Contract which conflicts with the laws of Montana or federal law is hereby amended to conform to the minimum requirements of such laws.

5.04 **Misstatements on Application: Effect**
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of this Contract, all statements made by the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Contractholder, a copy of which has been furnished to such Contractholder.

5.05 **Legal Actions**
No action at law or in equity will be brought to recover on this Contract before 60 days after written proof of loss has been filed in accordance with requirements of this Contract. No such action shall be brought after the expiration of any applicable statutes of limitations.

5.06 **Not in Lieu of Workers' Compensation**
This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

5.07 **Certificate of Insurance**
Delta Dental will issue to the Contractholder an electronic file containing a certificate/Evidence of Coverage booklet summarizing the Benefits to which Enrollees are entitled and to whom Benefits are payable. Each Primary Enrollee will have electronic access to the certificate. Delta Dental will also furnish a hard copy to a Primary Enrollee or the Contractholder upon request. The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract will materially affect any Benefits described in the certificate, new certificates or amendments showing the change will be issued.

5.08 **Publications About Program**
Contractholder and Delta Dental agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

5.09 **Provider Relationships**
Contractholder and Delta Dental agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to Enrollees does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

5.10 **Notice: Where Directed**
All formal notices under this Contract must be in writing and sent by email, facsimile (fax), first-class United States mail, overnight delivery service or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully pre-paid postage.

Contractholder shall designate in writing on the application a representative for purposes of receiving notices from Delta Dental under this Contract. Contractholder may change its representative at any time with 30 days' written notice to Delta Dental. The Contractholder's representative shall disseminate notices to the Enrollees within 30 days' of receipt.

5.11 **Indemnification**
Contractholder will indemnify, defend and hold harmless Delta Dental, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Agreement.

Delta Dental will indemnify, defend and hold harmless Contractholder 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.

5.12 **Compliance with Administrative Simplification, Security and Privacy Regulations**
Contractholder and Delta Dental shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Enrollee information including executing a Business Associate Addendum as required by Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Contractholder and Delta Dental agree that this Contract shall incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA, HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

5.13 **Impossibility of Performance**
Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

5.14 **New Enrollees**
New eligible Enrollees may be added in accordance with the terms of this Contract under section 2.05.

5.15 **Third Party Administrator ("TPA")**
Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

5.16 **Holding Company**
Delta Dental is a member of the Insurance Holding Company System of Delta Dental of California (the "Enterprise"). There are service agreements between and among the controlled member companies of the Enterprise. Delta Dental is a party to some of these service agreements, and it is expected that the services, which include certain ministerial tasks, will continue to be performed by these controlled member companies, which operate under strict confidentiality and/or business associate agreements. All such service agreements have been approved by the respective regulatory agencies.

5.17 **Mutual Confidentiality**
Contractholder and Delta Dental agree to maintain confidential information using the same degree of care (which shall be no less than reasonable care) as each uses to protect its own confidential information of a similar nature and to use confidential information only for specified purposes. Confidential information includes any information which the owner deems confidential, whether marked as confidential or otherwise clearly identifiable as confidential and includes information not generally known by the public or by parties which are competitive with or otherwise in an industry, trade or business similar to the owner of the confidential information. The recipient of confidential information shall notify the owner of any unauthorized disclosure or breach of confidentiality as soon as possible after discovery and without unreasonable delay.

5.18 **Trademarks: Service Marks**
Unless specifically allowed in this Contract, neither party shall use the name, trademarks, service marks or other proprietary branding of the other party without the advance written approval of the other party.

## ARTICLE 6 - TERMINATION AND RENEWAL

6.01 This Contract may be terminated only as follows:

- By Delta Dental,
  (1) upon 90 days' written notice if Contractholder fails to furnish Delta Dental a list of all Enrollees as required under section 2.01; or
  (2) upon 90 days' written notice if Contractholder fails to permit Delta Dental to inspect Contractholder's records as called for under section 2.02; or
  (3) upon 30 days' written notice if Contractholder fails to pay Premiums, in the amount and manner required by Article 3.
- By Delta Dental, with 90 days' written notice if the Contractholder reports fewer than the Minimum Number of Primary Enrollees shown in Attachment C for three (3) consecutive months.
- By Delta Dental at the end of a Contract Term upon 90 days' written notice.

6.02 If this Contract terminates under section 6.01 first and/or second bullet, Contractholder may become obligated upon termination to pay Delta Dental for that portion of the monthly Premium which constitutes for the current Contract Term Delta Dental's direct costs of administering this Contract multiplied by the remaining number of months from the date of termination to the expiration of the current Contract Term, but the amount will not exceed 25% of the total Premium for the entire Contract Term.

6.03 If Contractholder notifies Delta Dental that it intends to terminate this Contract upon less than 90 days' notice, section 6.02 will apply as if Delta Dental terminated this Contract under section 6.01 first and/or second bullet(s).

6.04 Delta Dental will not be required to do Pre-Treatment Estimates if this Contract is terminated for any cause nor will Delta Dental be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while this Contract was in effect as stated in section 2.08.

6.05 Delta Dental will provide 60 days' advance written renewal notice prior to the end of the initial or any subsequent Contract Terms indicating if Premiums and/or Benefits will remain the same or change. The Contractholder's payment of the Premium indicated in the renewal notice for the new Contract Term will signify the Contractholder's acceptance of the renewal. If the Contractholder fails to provide written notification to Delta Dental of non-renewal by the date indicated in the renewal letter and/or does not pay the Premiums indicated in the renewal notice with the new Contract Term, Delta Dental will terminate this Contract under section 6.01 second bullet, item (3).

## ARTICLE 7 - ATTACHMENTS

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

| | |
|---|---|
| **Attachment A** | **Deductibles, Maximums and Contract Benefit Levels** |
| **Attachment B** | **Services, Limitations and Exclusions** |
| **Attachment C** | **Group Variables** |

## Attachment A
## Deductibles, Maximums and Contract Benefit Levels

**Contractholder:** CITY OF LAUREL

**Group Number:** 15937-51611 **Effective Date:** JULY 1, 2016

| Deductibles & Maximums | |
|---|---|
| **Annual Deductible** | $50 per Enrollee each Calendar Year<br>$150 per family each Calendar Year |
| Deductibles waived for | Diagnostic & Preventive and Orthodontic Services |
| **Annual Maximum** | $1500 per Enrollee per Calendar Year<br>Annual Maximum waived for Diagnostic and Preventive Services. |
| **Orthodontic Maximum** | $1500 per dependent child Enrollee to age 26 per lifetime |

| Contract Benefit Levels | | |
|---|---|---|
| **Dental Service Category** | **Delta Dental PPO Providers†** | **Delta Dental Premier® and Non-Delta Dental Providers†** |
| Delta Dental will pay or otherwise discharge the Contract Benefit Level shown below for the following services: | | |
| **Diagnostic and Preventive Services** | 100% | 100% |
| **Basic Services** | 80% | 80% |
| **Major Services** | 50% | 50% |
| **Orthodontic Services** | 50% | 50% |

† Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

**CHOOSING A PROVIDER THAT IS NOT A PPO PROVIDER**
The Premier Provider has not agreed to the features of the PPO program; however, Enrollees may still receive dental care at a lower cost than if Enrollees use a Non-Delta Dental Provider.

If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by the PPO or Premier Providers. Non-Delta Dental Providers can balance bill for the difference between the Program Allowance and the Non-Delta Dental Provider's Accepted Fee. For a Non-Delta Dental Provider, the Accepted Fee is the Provider's Submitted Fee.

# Attachment B
## Services, Limitations and Exclusions

**Contractholder:** CITY OF LAUREL

**Group Number:** 15937-51611 **Effective Date:** JULY 1, 2016

***Description of Dental Services***
Delta Dental will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive: cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
- **Basic Services**
  - (1) Oral Surgery: extractions and other surgical procedures (including pre- and post-operative care).
  - (2) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
  - (3) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (4) Periodontics: treatment of gums and bones supporting teeth.
  - (5) Palliative: emergency treatment to relieve pain.
  - (6) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
  - (7) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
  - (8) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
  - (9) Specialist Consultations: opinion or advice requested by a general dentist.
- **Major Services**
  - (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
  - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- **Orthodontic Services**
  Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.
- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

***Limitations***

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:
a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration;
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
e) an overdenture instead of denture.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Exam and cleaning limitations
a) Delta Dental will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year.
b) A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided.
c) Note that periodontal cleanings, Procedure Codes that include periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
d) Caries risk assessments are allowed once in 36 months for Enrollees age three (3) to 19.

(3) X-ray limitations:
a) Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(4) Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.

(5) Space maintainer limitations:
a) Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 14.
b) Recementation of space maintainer is limited to once per lifetime.
c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(6) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(7) Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime only when Orthodontic Services are covered. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

(8) Application of Sealants as a Benefit is limited to dependents up to age 16 through the completion of the procedure or the date eligibility terminates, whichever occurs first. Treatment with Sealants as a covered service is limited to application to 1st and 2nd permanent molars. Applications to deciduous teeth or teeth with caries are not covered services. Sealants will be replaced only after 2 years have elapsed following any prior provision of such materials.

(9) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Delta Dental will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(12) Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.

(13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

(14) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(15) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(16) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(17) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(18) Periodontal limitations:
   a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
   b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.
   c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
   d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planning in the same quadrant.
   e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

(19) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(20) The following Oral Surgery procedure is limited to age 19 or orthodontic limiting age: transseptal fiberotomy/supra crestal fiberotomy, by report.

(21) The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.

(22) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month period.

(25) Crown repairs are covered not more than twice in any 60 month period.

(26) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than twice in any 60 month period.

(27) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.

(28) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(29) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(30) Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(31) Limitations on Orthodontic Services
   a) The maximum amount payable for each Enrollee is shown in Attachment A.
   b) Benefits for Orthodontic Services will be provided in Monthly payments based on the Enrollee's continuing eligibility.
   c) Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
   d) Benefits are not paid for orthodontic retreatment procedures.
   e) Benefits for Orthodontic Services are limited to dependent child Enrollees under age 26.

***Exclusions***
**Delta Dental does not pay Benefits for:**
(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) laboratory processed crowns for Enrollees under age 12.

(12) fixed bridges and removable partials for Enrollees under age 16.

(13) interim implants and endodontic endosseous implant.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(16) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.

(18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(21) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(22) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.

(24) services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.

(25) missed and/or cancelled appointments.

## Attachment C
## Group Variables

**Contractholder Name:** CITY OF LAUREL

**Group Number:** 15937-51611

**Effective Date:** JULY 1, 2016

**Contract Term:** JULY 1, 2016 THROUGH JUNE 30, 2017

**Termination (Minimum Number of Primary Enrollees):**

- Less than 5 Primary Enrollees or a reduction of 30% or more in the number of Primary Enrollees over three (3) consecutive months.

**Premiums:**

| **Monthly Amount:** | |
|---|---|
| Per Primary Enrollee: | $37.30 |
| Per Primary Enrollee and Spouse: | $68.68 |
| Per Primary Enrollee and Child(ren): | $72.16 |
| Per Primary Enrollee and Family: | $114.28 |

***Premiums are to be remitted to:***

**Allied Administrators**
**Delta Dental Insurance Company**
**P.O. Box 45793**
**San Francisco, CA 94145-0793**

**Payment Breakdown:**
Payment Breakdowns are shown on the application signed by the Contractholder and accepted by Delta Dental.

Delta Dental shall receive a full month's Premium for all Enrollees.

Contractholder may charge persons electing continued coverage pursuant to Title X of P.L. 99 as permitted by law.

PEAK1 ADMINISTRATION

Scanned to Peak1
5-4-16

City of Laurel
Attn: Benefit Contact
PO Box 10
Laurel, MT 59044

April 5, 2016

RE: July 2016 VSP Renewal

Dear Benefit Contact

We appreciate your business and thank you for choosing VSP and Peak1 Administration. We are pleased to present you with our VSP contract renewal information. We are committed to providing you with quality plan designs combined with excellent customer service. As part of the law, carriers are required to apply additional taxes to their rates. Your new rates include all of the new Affordable Care Act (ACA) taxes required by Federal Law.

| Rates through 6/30/2016 | | 7/1/2016 Rates | |
|---|---|---|---|
| EE Only | $6.59 | EE Only | $6.59 |
| EE+Spouse | $13.20 | EE+Spouse | $13.20 |
| EE+Child(ren) | $14.13 | EE+Child(ren) | $14.13 |
| EE+Family | $22.57 | EE+Family | $22.57 |

Please sign below that you agree to the rates stated above and will renew as is:

Signature: Heidi Jensen 5-4-16

If you need to make any changes, please complete the attached employer agreement and we will update accordingly.

Your business is very important to us. Thank you for allowing Peak1 Administration to serve your insurance and account based product needs. If you have any questions about your renewal, please give us a call at 877.404.9443 or email benefits@mypeak1.com. Thank you for your continued confidence in VSP and Peak1 Administration.

Sincerely,

Amy Markham
Implementation Coordinator
Peak1 Administration